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# *Promoting Reproductive Health in Uganda:* Evaluation of a National IEC Program

The Uganda Family Planning Promotion Project and
The Delivery of Improved Services for Health Project

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# Abbreviations

| | |
|---|---|
| AIC | Aids Information Center at Baumann House |
| AIDS | acquired immune deficiency syndrome |
| CBD | community-based distribution |
| CHW | community health worker |
| DHS | Demographic and Health Surveys |
| DISH | Delivery of Improved Services for Health Project |
| EA | enumeration area |
| FE | field educator |
| FGD's | focus group discussions |
| FPAU | Family Planning Association of Uganda |
| GOU | Government of Uganda |
| GNP | Gross National Product |
| HIV | human immunodeficiency virus |
| IDI's | in-depth interviews |
| IEC | information, education, and communication |
| IUD | intrauterine device |
| JHU/PCS | Johns Hopkins University/Population Communication Services |
| JHU/CCP | Johns Hopkins Center for Communication Programs |
| LAM | lactational amenorrhea method |
| MOH | Ministry of Health |
| NFP | Natural Family Planning |
| NGO's | nongovernment organizations |
| PAC | Project Advisory Committee |
| PATH | Program for Appropriate Technology in Health |
| PIT | Polytechnic of Information Technology |
| PSU | primary sampling unit |
| RC | Resistance Council |
| R&E | research and evaluation |
| R/R/R/R | Runyankore/Rukiga/Rutoro/Runyoro |
| SOMARC | Social Marketing for Change |
| STDs | sexually transmitted diseases |
| UFPPP | Uganda Family Planning Promotion Project |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

# Summary

## The Uganda Family Planning Promotion Project

Between 1992 and 1994 the Ministry of Health (MOH) in Uganda carried out a project to increase the use of modern family planning methods among married couples in urban areas of eastern, central, and Southwestern Uganda. Named the Uganda Family Planning Promotion Project (UFPPP), the intervention was coordinated by the Family Planning Association of Uganda (FPAU), on behalf of the MOH. The United States Agency for International Development (USAID) provided funding for the project and technical assistance was provided by Johns Hopkins University / Population Communication Services (JHU / PCS). A multimedia effort, the campaign entailed development and widespread dissemination of the following information, education, and communication (IEC) materials:

- A national family planning logo, the "Yellow Family Planning Flower,"
- A year-long, multilingual radio serial drama about family planning,
- More than 300 broadcasts of radio spots promoting the logo and family planning,
- 80,000 family planning posters,
- 200,000 family planning leaflets, and
- 600 family planning clinic signposts

The evaluation strategy comprised a pre- and post-campaign household survey, service statistics from 24 sentinel clinic sites, and pre- and post-campaign exit interviews with new family planning clients at these sentinel clinics. Results show that the campaign reached a majority of the respondents and influenced the behavior of many. Nearly 92 percent of the respondents on the post-campaign household survey and virtually all of the clinic respondents reported exposure to at least one of the campaign's IEC materials. About 86 percent recognized the family planning logo, and of these, nearly all understood the logo's meaning.

In the clinics, family planning providers were more likely to use IEC materials after the campaign than they had been before the campaign. There was an improvement in perceived social support for family planning, an increase in numbers of people wishing to use family planning, and an increase in the proportion of women desiring no more children. During the campaign, FPAU facilities and community-based providers recorded a monthly average of 1,225 new users compared with the 643-per-month average before the campaign.

Multivariate analysis found that the people recalling the most campaign materials were also the most likely to be using family planning, regardless of their age, gender, education parity, attitudes toward family planning, socioeconomic status, and place of residence (*i.e.* urban or rural). Respondents with the highest campaign recall were three times more likely to be using contraception than were those with no exposure (odds ratio=3.3) and the relationship was stronger for men (odds ratio=4.0)than women (odds ratio=3.4).

Household survey results also show that contraceptive users were more likely to choose modern methods after the campaign -- before the campaign 68 percent of users were using modern

methods, but this proportion increased to 74 percent after the campaign. This was especially the case among respondents of lower education levels as well as among those in the younger age groups. Multivariate analysis also showed that the more campaign materials an individual could recall, the more likely he or she was to use modern methods. Use of non modern methods remained largely unchanged.

Radio, the main mass communication medium used in this campaign, became the project area's foremost source of family planning information. The proportion of household survey respondents citing it as their main source of family planning information quadrupled during the campaign.

**The Delivery of Improved Services for Health Project**

The end of the UFPPP coincided with start of the Delivery of Improved Services for Health (DISH) project, a five-year initiative of the Government of Uganda (GOU) and USAID. Thus, the evaluation of the UFPPP provided an opportunity to set IEC baseline markers for the DISH project. Special questions on acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), abortion, and breastfeeding were included in the follow-up survey.

Data reveal that nearly 35 percent of all household survey respondents, especially those with no formal education, were uncertain about their risk of HIV / AIDS. Men (44 percent) were more likely than women (33 percent) to consider themselves *not* at risk. About 33 percent of men (compared with 8 percent of women) reported having had extramarital intercourse within the previous year. Roughly 18 percent of the total sample had been tested for HIV / AIDS (although 23 percent of those reporting extramarital relations had been tested). Respondents with no education were the least likely to have been tested but the most likely to want testing. Those in the youngest age group were also the most likely to want testing. About 77 percent of respondents who had heard of HIV / AIDS or other STDs said they had changed their behavior since learning of them. Those with the least education and those in the younger age groups, however, were the least likely to report a change.

Condom use rose appreciably among contraceptive users during the UFPPP campaign, from 17 percent to 23 percent. General mistrust persisted, however; people still believed that most condoms break, have holes, and are difficult to use consistently. Only 60 percent of survey respondents believed condoms could protect against HIV / AIDS; 72 percent believed condoms protected against other STDs. The data suggest that people are still uncomfortable about revealing HIV-positive status: When asked whether they would tell a partner if they were HIV-positive versus if they had another STD, respondents were more likely to disclose other STDs.

The survey also inquired about breastfeeding habits. Breastfeeding appears common in the study area, with 86 percent of the respondents (or their spouses) having breastfed their youngest child. The average duration of breastfeeding was 14 months (excluding persons still breastfeeding), although respondents felt a child should be breastfed for an average of 19 months. About 10 percent of current family planning users reported breastfeeding as their method of contraception. There is considerable confusion about breastfeeding and HIV infection. Nearly half the respondents believe that it is wrong for an HIV-positive mother to breastfeed her baby.

# Chapter I.
# Introduction

Uganda is a landlocked East African country lying astride the equator. It has a population of about 20 million, predominantly of Bantu, Nilo-Hamite, Nilotic, and Sudanese origin. The official language is English, while Luganda is a widely spoken language. Uganda suffered from a 25-year period of military unrest and outright civil war that ended in the late 1980s with the installation of Yoweri Kaguta Museveni as the president. Since then, the country has enjoyed fiscal and political stability. The economy is primarily agricultural, with a per capita gross national product (GNP) of US $170 (Population Reference Bureau 1994; Walker 1992). Some 66 percent of the men and 35 percent of the women can read. Almost half the population is under 15 years of age. Total fertility averages 6.9 births (Uganda Demographic and Health Survey [UDHS] 1995). A tradition of early childbearing has led both to a young population and to high fertility: 60 percent of Ugandan women have their first babies before they are 20 years old (UDHS 1989).

Organized family planning services in Uganda began in 1957 with the founding of the Family Planning Association of Uganda (FPAU), an affiliate of the International Planned Parenthood Federation. In 1988, the government of Uganda established a population secretariat as part of the Ministry of Planning and Economic Development. Family planning services are now provided through clinics operated by the government, by FPAU, by other nongovernment organizations, and by private physicians, nurses, and midwives. Services and/or supplies are also available from pharmacies, chemists/shops, and similar commercial outlets, as well as through community-based distribution (CBD) agents in certain parts of the country. In the past, family planning efforts were concentrated in urban areas, but in recent years, the government has increased efforts to promote family planning in rural areas.

Not only does Uganda have to grapple with a high fertility rate, but it also has one of the highest rates of human immunodeficiency virus (HIV) infection in the world. At present, roughly 10 percent of the population is thought to be infected with HIV (AIDS Control Program and World Health Organization [WHO] 1991). As a result, life expectancy at birth in Uganda is 42 years (PRB 1994) and there are estimates that this will drop to 31.5 years by the year 2010. There is a sharp difference in HIV/AIDS prevalence between urban and rural areas. In the capital city of Kampala, women attending antenatal clinics have a HIV seropositive prevalence rate of 25 percent; in selected rural areas, the rate is 4 to 5 percent (US Department of Commerce, 1994). The Ugandan Government established the Uganda AIDS Commission to direct, monitor, and coordinate its AIDS Control Strategy under the leadership of the president himself.

## The Uganda Family Planning Promotion Project

The Uganda Family Planning Promotion Project (UFPPP) was an information, education, and communication (IEC) campaign conceived by the Ministry of Health and implemented by FPAU, with financial support from the United States Agency for International Development (USAID) and technical assistance from Johns Hopkins University/Population Communication Services

(JHU/PCS). The project began in July 1992 and was completed in October 1994. Some activities, such as the radio serial drama, continued for a short time after that date, however.

In 1992, when the project began, family planning services were not widely available in Uganda. Several new projects, however, had begun expanding service availability, predominantly in the most populous areas—Eastern, Central, and Southwest regions. The general goals of the UFPPP were to provide improved information about *modern* family planning methods and where they could be obtained, and to encourage all married men and women in these three regions to seek family planning services. Specifically, the project objectives were to:

- Contribute to an increase in the use of modern family planning methods among married couples in urban areas;
- Double the number of new clients at selected family planning clinics; and
- Increase the number of urban *men* with favorable attitudes toward the use of modern family planning methods.

To accomplish these goals, FPAU contracted for the services of an advertising agency to design and popularize a national family planning logo (see front cover) and a radio producer to create and broadcast a radio soap opera in vernacular languages to motivate married couples to discuss family planning and visit local family planning clinics. In addition, FPAU worked closely with CBD agents to organize megaphone talks about family planning in men's gathering places.

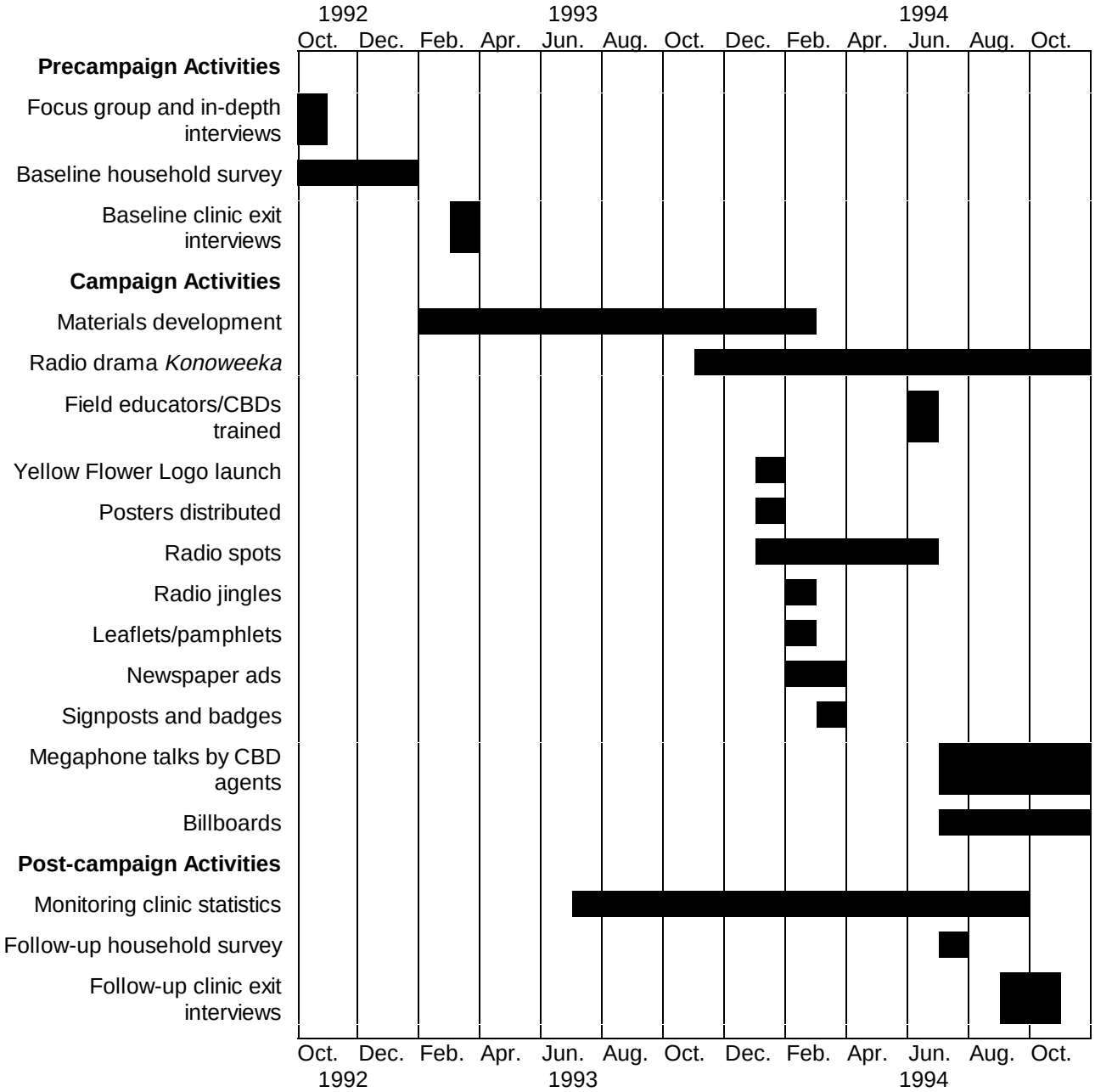
Specific project products and activities (scheduled as shown in Figure 1.1), included:

- Placement of the Yellow Flower national family planning logo on signboards at 600 clinics offering family planning services and on 10,000 badges worn by service providers trained in family planning;
- A radio serial drama (soap opera) with 52 segments to be broadcast in Runyankore, Luganda, and Luo languages for a year on Radio Uganda;
- Radio spots and a jingle with motivational messages telling listeners to look for the Yellow Flower logo for family planning services and information;
- Posters and billboards in the Runyankore, Luganda, and Luo languages, as well as in English, showing the Yellow Flower logo and telling people that they can get family planning services where they see the logo;
- Leaflets giving a couple's testimonial about family planning and descriptions of available methods in Runyankore, Luganda, Luo, and English;
- Newspaper advertisements in vernacular languages and English showing the Yellow Flower logo and telling readers that they can get family planning information and services where they see the logo;

- A national launching ceremony for the Yellow Flower family planning logo in Kampala; and

- Training of 256 field workers and CBD agents in delivering talks with megaphones on family planning to men.

**Figure 1.1.**
**Activities Timetable: Uganda Family Planning Promotion Project, 1992-1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994)

One of the first activities of the UFPPP was the establishment of the IEC Project Advisory Committee (PAC), whose task was to provide overall guidance to the project, review the IEC materials, and serve as a coordinating body for national family planning IEC efforts. The PAC included all the major government and nongovernment family planning organizations in the country. FPAU coordinated the project for the MOH.

Next, UFPPP began the formative research phase, drawing information from focus group discussions (FGDs), in-depth interviews (IDIs), and a baseline household survey. This research guided the development of a radio soap opera, *Konoweeka* ("A Stitch in Time"), which was aired beginning November 1993 in Runyankore, Luganda, and Luo languages. The national family planning logo, the Yellow Flower, was launched on January 29, 1994, during a ceremony at which the Vice President was guest of honor. Yellow Flower posters were distributed nationwide at family planning clinics, hospitals, commercial outlets, and locations used for outdoor advertising. Print materials were distributed by students in various parts of the country under the supervision of the local FPAU office. Radio jingles and spots promoting the logo and family planning were broadcast to coincide with the logo launch. Leaflets describing family planning methods also were produced and were distributed at family planning service delivery sites, and newspaper advertisements publicized the Yellow Flower.

One important component of the UFPPP was a campaign to motivate male involvement in family planning and to encourage husbands to support their wives' interest in family planning. To accomplish this, more than 250 field educators and CBD agents were trained in motivational skills in June 1994. Once trained, they returned to their communities and, in addition to making their usual family planning home visits, conducted bimonthly outdoor community education sessions.

## Delivery of Improved Services for Health

The Delivery of Improved Services for Health (DISH) Project, a five-year reproductive health project funded by USAID, was launched in June 1994. The goal of the DISH project is to reduce the incidence of HIV and other sexually transmitted diseases (STDs), increase the prevalence of modern contraceptives, and improve care before, during, and after childbirth. This goal will be achieved by increasing the availability and use of integrated family planning, maternal health, STD, and HIV services offered by the public and private sector.

The DISH project covers 10 districts: Jinja, Kamuli, Kampala, Masindi, Luwero, Masaka, Rakai, Mbarara, Ntungamo, and Kasese. Key interventions are:

- Training nurses and midwives to provide reproductive health services;
- National and district IEC campaigns;
- Implementation of a logistics and information system to ensure availability of contraceptive commodities at private and public service delivery sites; and

- Review and rationalization of existing health care financing in selected clinics.

Because the UFPPP follow-up household survey was conducted in four DISH districts, it provided an opportunity to gather some baseline data for the DISH project (see Figure 1.2). The follow-up household survey questionnaire, therefore, added items on selected DISH-related IEC topics, including knowledge of and attitudes toward HIV/AIDS and other STDs, use of HIV/AIDS/STD counseling and treatment facilities, preventive practices adopted in response to HIV/AIDS/STDs. The findings are included in this report.

## Plan of the Report

The remainder of this report presents the findings of the UFPPP evaluation, as well as baseline information on the DISH project. Chapter II details the technical methods used to evaluate the findings including the design of the household and clinic studies. It discusses the sampling strategies, data collection, and analysis. It describes the monitoring of clinic service statistics and the methodology for the exit interviews. Chapter III presents demographic characteristics of the follow-up household survey respondents, and Chapter IV presents their fertility awareness, attitudes, and behavior. Chapter V presents data on HIV/AIDS and other STDs, information collected as part of the DISH project baseline. Chapter VI discusses other reproductive health issues addressed in the questionnaire, including breastfeeding and abortion. Chapter VII examines the impact of UFPPP in three ways: 1) campaign impact is assessed by comparing baseline survey behavioral indicators to the same indicators in the follow-up survey (adjusted data), 2) multivariate regression analysis is used to explain the relationship between campaign exposure and contraceptive use, and 3) evidence from clinic statistics and clinic exit interviews further assess campaign impact. Chapter VIII presents the conclusions of the evaluation and makes recommendations for future IEC interventions. A detailed list of the IEC interventions and the findings of multivariate analysis are found in the appendixes. Copies of the follow-up household questionnaires and clinic exit interviews are available on request (see page ii).

**Figure 1.2. Map of Uganda Showing Project Survey Districts, 1992-1994**


SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

# Chapter II.
# Evaluation Methods

The evaluation of the Uganda Family Planning Promotion Project (UFPPP) was based on the Communication Design and Evaluation System (CODES), the evaluation framework used for JHU/PCS projects. The data came from three sources: baseline (pre-campaign) and follow-up (post-campaign) household surveys, interviews with women in a sample of family planning clinics before and after the campaign, and tracking of service statistics at these facilities.

## Household Surveys

The baseline household survey was conducted between November 1992 and February 1993. The follow-up survey was conducted in July 1994. The surveys were conducted in urban and peri-urban areas of Kampala, Jinja, Masaka, and Mbarara districts. These districts were selected because they were in the target areas of the UFPPP.

**Sampling procedure**. To ensure a cross-section of survey respondents, the urban areas in each district were stratified by socioeconomic status. There were three socioeconomic groups per district: upper-middle, lower-middle, and lower.[1] In addition, an adjacent peri-urban area outside the town's municipal boundaries was selected in each district (see Table 2.1). All areas in the study were within 20 kilometers of a family planning service delivery site and thus the resident population had access to services. Areas occupied by persons in the highest socioeconomic groups or elites were excluded from the survey.

In each urban area, the three socioeconomic strata were defined as the primary sampling units (PSU). Within each PSU, two adjacent enumeration areas (EAs) were chosen in a manner that allowed adequate geographic distribution of the sample. All the dwellings in the selected EA were then listed. Efforts were made to list at least 2,000 households to enable a sufficient sampling interval and back-up sample. Participating households were selected from the sampling frame using systematic random sampling. In each stratum about 80 households were selected. The goal for the survey was 1,280 complete and usable interviews. Because the UFPPP was directed primarily to urban couples, urban households were deliberately over-sampled in the survey.

One respondent in each household selected was randomly chosen for the interview. To be eligible for the study, an individual had to be married and between ages 20 and 35 for women and between 20 and 40 for men. Respondents were purposively selected to split the sample evenly between men and women.

[1] These socioeconomic classifications are based on the Urban Planners Residential Zoning System (UPRZS) used by the Ministry of Housing, Lands, and Urban Development, as well as the offices of the Town Planner. The UPRZS classifies residential areas according to the density of residential units (space allocation) and the population density. Low-income areas have the highest density; high-income areas have the lowest density. The peri-urban areas selected were relatively homogenous and therefore were not stratified.

The follow-up survey returned to the same geographic areas surveyed in the baseline survey (see Figure 1.2), and participating EAs were randomly chosen. A new list of households was made, and the same procedures used to list and select households in the baseline were used in the follow-up survey. This improved the likelihood that the baseline and follow-up samples would be comparable. The baseline survey had 1,347 successful interviews; the follow-up had 1,323.

**Table 2.1.**
**Sites Used in the Survey, by District and Income Level, Uganda, 1992-1994**

| District | Urban Sites | Peri-urban Sites |
|---|---|---|
| Kampala | Kisenyi (LI)<br>Nakawa (LM)<br>Bugoloobi (UM) | Kitagobwa |
| Jinja | Walukuba (LI)<br>Maggwa (LM)<br>Rippon Falls (UM) | Budondo |
| Masaka | Kimanya Parish (LI)<br>Kirumba RC1 (LM)<br>Bwala Hill Area (UM) | Kinoni RC1 |
| Mbarara | Kizungu (LI)<br>Kakoba (LM)<br>Boma (UM) | Kaberebere |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: LI = low income
LM = lower-middle income
UM = upper-middle income

**Data collection**. The questionnaire used in the follow-up survey was an adaptation of the baseline questionnaire, with additional questions based on the Delivery of Improved Services for Health Project's IEC objectives. The questionnaire was pretested twice before translation into Luganda and Runyankore. After further pretesting of the vernacular versions, it was produced for field work.

Thirty-two researchers, 16 men and 16 women, were recruited as field interviewers. They were graduate and undergraduate students at Makerere University in Kampala, and all had experience in social science research. All came from the respective study areas, were fluent in the interview language, and had participated in the pretesting of the questionnaire. Before the data collection, they received a five-day training session that included two field trials. Training was conducted by the research team using a manual developed for this survey. Fieldwork was supervised by the research team. Supervisors made spot checks by re-interviewing a sample of respondents, conducting field edits of the questionnaires, and identifying re-interviews as necessary. Interviewers were provided with UFPPP promotion materials such as posters, leaflets, and logo templates to show to respondents in determining campaign exposure.

After the field work was completed, some of the field research assistants served as data coders and editors. Following data collection, questionnaires were checked for accuracy and

completeness. Open-ended questions were coded and the questionnaires edited as appropriate. Data were entered using Integrated System for Survey Analysis© (ISSA), a software package that enables automatic range and internal consistency checks. A sample of questionnaires was double-entered to check for data-entry flaws; corrections were then made.

**Data analysis**. Univariate analysis was conducted to obtain frequency distributions for key variables and to examine them for outliers and unusual responses. Data were further checked for internal consistency and variables were recoded as appropriate. Bivariate analyses were used to uncover preliminary relationships between campaign exposure and outcomes of interest. Multivariate analysis was used to examine the significance of these relationships, controlling for confounding variables. The measure of association was the odds ratio.

**Study limitations**. Because the study was limited to married couples ages 20 to 40 years, conclusions cannot be drawn about unmarried people or people outside this age range. (Ugandan men and women under age 20 and over age 40 may need family planning, but these populations were not the focus of the intervention.) Respondents in both surveys had considerably higher levels of education than average Ugandans. For example, while 48 percent of the women in the follow-up survey reported having secondary school or higher education, only 14 percent of women at the national level report the same educational achievement (UDHS 1995). In addition, because the study was limited to urban and peri-urban areas in four districts, the data cannot be considered nationally representative. It is also possible that other factors responsible for family planning behavior were not assessed in this study. For example, anecdotal indications suggested that respondents in the follow-up survey were of lower socioeconomic status than those in the baseline. Efforts to adjust for these differences were made during multivariate analysis and by standardizing the data wherever baseline and follow-up comparisons are made.

## Clinic Studies

Two types of clinic studies were conducted as part of the UFPPP evaluation: monitoring of service statistics at a sample of service delivery points and clinic exit interviews of new family planning acceptors.

**Clinic service statistics**. Service statistics were monitored at 24 FPAU clinics over a 15-month period to track attendance for four months before and 11 months during campaign activities. In each clinic, clinic staff recorded the number of new family planning clients as well as the number of continuing clients every month.

**Clinic exit interviews**. To assess the impact of the UFPPP campaign on service delivery, exit interviews were conducted with new family planning acceptors in March 1993, before the campaign (baseline), and in September 1994, at the end of the campaign (follow-up). These interviews were designed to evaluate service providers' use of print materials, to assess clients' comprehension of the materials, and to determine source of referral for family planning services. Baseline data were collected from 24 clinics, and follow-up data, from 21 of the original 24 sites. The clinics were located in the vicinity of Lira, Mbarara, Kampala, Masaka, and Jinja.

Approximately half the clinics were operated by FPAU, one-third by the MOH, and about one-tenth each by East Ankole and Busoga Dioceses. More than three-fourths of the clinics were in urban areas. The exit interviews were conducted using a pretested questionnaire translated into Luo, Luganda, and Runyankore. Ten trained research assistants interviewed new female clients at participating clinics after the provider-client interaction had been completed. Supervision was provided by FPAU.

# Chapter III.
# Follow-up Household Survey Respondents

## Demographic Characteristics

Consistent with the survey design, respondents were almost evenly split between men and women and all respondents were urban or peri-urban residents. The mean age was 31 years for men and 26 years for women (see Table 3.1). (See Chapter VII for a comparison of DISH baseline and UFPPP follow-up findings.)

**Table 3.1.**
**Percent Distribution of Respondents by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| Characteristic | Number (1,323) | Percent (100.0) |
|---|---|---|
| **Gender** | | |
| Male | 628 | 47.6 |
| Female | 691 | 52.4 |
| **Location** | | |
| Urban | 980 | 74.1 |
| Peri-urban | 342 | 25.9 |
| **District** | | |
| Kampala | 297 | 22.5 |
| Jinja | 361 | 27.3 |
| Masaka | 369 | 27.9 |
| Mbarara | 295 | 22.3 |
| **Education** | | |
| None | 62 | 4.7 |
| Primary | 533 | 40.4 |
| Secondary | 480 | 36.3 |
| Beyond secondary | 246 | 18.6 |
| **Age** | | |
| 20-24 | 383 | 29.2 |
| 25-29 | 375 | 28.6 |
| 30-34 | 330 | 25.2 |
| 35-40 | 222 | 17.0 |
| **Religion** | | |
| Protestant | 519 | 39.2 |
| Catholic | 489 | 37.0 |
| Muslim | 301 | 22.8 |
| Traditional/Other/None | 14 | 1.0 |
| **Mean Age (years)** | | |
| All (n=1,311) | 28.3 | |
| Men (n=616) | 30.9 | |
| Women (n=691) | 26.1 | |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n = 1,323; Unadjusted data. Totals may vary because of missing values.

## Marital Arrangements

About 28 percent of the study group were in polygamous unions—21 percent of the men and 34 percent of the women (see Table 3.2). Among women in polygamous unions, roughly one-half had one co-wife, the other half had two or more co-wives (data not shown). There was a close correspondence between polygamy and education level, with less educated couples being more likely to practice polygamy. Roughly 16 percent of women were pregnant at the time of the interviews (see Table 3.2).

**Table 3.2.**
**Percent Distribution of Respondents in Polygamous Unions and Percent Distribution of Respondents Pregnant at the Time of the Interview, by Selected Characteristics,**
**Follow-up Survey, Uganda, 1994**

| Characteristic | In Polygamous Unions [a] (n=1,323) | Pregnant at the Time of the Interview (n=1,276) |
|---|---|---|
| **All** | 27.5 | 15.7 |
| **Gender** | | |
| Male | 20.7* | 16.6 [b] |
| Female | 34.0* | 14.6 |
| **Location** | | |
| Urban | 27.3 | 15.6 |
| Peri-urban | 28.3 | 16.0 |
| **District** | | |
| Kampala | 22.3 | 12.1* |
| Jinja | 29.9 | 20.4* |
| Masaka | 30.1 | 13.1* |
| Mbarara | 26.8 | 16.4* |
| **Education** | | |
| None | 40.0* | 6.6 |
| Primary | 32.0* | 16.8 |
| Secondary | 27.0* | 15.7 |
| Beyond secondary | 15.1* | 15.1 |
| **Age** | | |
| 20-24 | 26.8 | 20.3* |
| 25-29 | 24.8 | 16.4* |
| 30-34 | 29.6 | 14.3* |
| 35-40 | 30.3 | 8.8* |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: * Demographic differences significant at $p \leq 0.05$.
n is the number of respondents who answered the question; unadjusted data.
[a] Excludes respondents who answered "don't know." [b] Refers to female partner.

## Material Wealth

The majority of respondents lived in houses constructed of permanent materials such as corrugated iron for steel roofs and brick for walls. One-third lived in semi-permanent housing (*e.g.*, mud walls and thatch or corrugated steel roof) and 5 percent lived in houses constructed

entirely of temporary materials. The power of electronic media to reach large numbers of Ugandans is reflected in the percentage of households with a radio (84 percent) and a television (33 percent). An additional 7 percent did not own a radio, but listened to someone else's. Thus 91 percent of the respondents owned or had access to a radio (see Table 3.3).

**Table 3.3.**
**Percent of Houses Constructed with Various Materials and Percent of Households Possessing Specific Materials Goods, Follow-up Survey, Uganda, 1994**

| Household Characteristic | Number | Percent |
|---|---|---|
| House Construction | | |
| Temporary materials | 64 | 4.9 |
| Semipermanent materials | 414 | 31.7 |
| Permanent materials | 830 | 63.4 |
| Household Possessions | | |
| Radio | 1,099 | 83.5 |
| Television | 416 | 32.6 |
| Bicycle | 731 | 56.4 |
| Motorcycle | 107 | 8.3 |
| Car | 149 | 11.5 |
| Land | 1,070 | 81.8 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

## Radio Listenership

At the time of the follow-up survey, there were three radio stations in Uganda: Radio Uganda, Capital Radio, and Radio Sanyu. Radio Uganda was and still is the only national radio station, and it operates three channels: Midland/Blue Channel, Green Channel, and Red Channel. Midland/Blue Channel broadcasts in Luganda, Runyankore, Rukonzo, and Rumba languages. The Green Channel broadcasts in English, Luganda, and Swahili. The Red Channel broadcasts mainly in English but also in Swahili, Luo, and other northern languages. During the family planning campaign, the Uganda government opened the airwaves and licensed two private radio stations, Capital Radio and Radio Sanyu. Both stations operate out of Kampala and are mainly confined to the city and surrounding areas. Most of their broadcasts are in English.

To assess new listening patterns, respondents were asked what stations they listened to most (see Table 3.4). Radio Uganda was listened to the most, reported by 80 percent of men and 71 percent of women. There was a significant difference in the listening practices of men and women—women were more likely to not know what station they listen to. There were only minor regional differences—urban residents were more likely to listen to the Blue Channel than peri-urban residents, while peri-urban residents were more likely to listen to the Red Channel or did not know.

**Table 3.4.**
**Percent Distribution of Respondents Who Own or Have Access to a Radio, by Station Listened to,**
**Follow-up Survey, Uganda, 1994**

| Station | All (n=1,149) | Men* (n=574) | Women* (n=572) | Urban** (n=846) | Peri-urban** (n=302) |
|---|---|---|---|---|---|
| Any Radio Uganda Station | 75.5 | 80.0 | 70.8 | 58.5 | 53.3 |
| Radio Uganda Blue/Midland | 57.2 | 62.7 | 51.4 | 58.5 | 53.3 |
| Radio Uganda Green | 11.5 | 9.1 | 14.0 | 11.2 | 12.3 |
| Radio Uganda Red | 6.8 | 8.2 | 5.4 | 5.3 | 10.9 |
| Radio Sanyu | 8.1 | 6.5 | 9.8 | 8.4 | 7.3 |
| Capital Radio | 3.7 | 4.1 | 3.5 | 3.8 | 3.6 |
| Others | 1.9 | 1.4 | 2.5 | 2.1 | 1.3 |
| Don't know | 10.8 | 8.2 | 13.5 | 10.6 | 11.3 |
| TOTAL | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number of those with access to a radio and who answered the question; unadjusted data.
* Differences between male and female patterns are statistically significant at p=0.001.
**Differences between urban and peri-urban patterns are statistically significant at p=0.047.

Because the reception of Sanyu and Capital radio stations is primarily in Kampala's vicinity, the data for Kampala were extracted to analyze listenership there. Among the 279 Kampala respondents who had access to a radio and answered the listenership question, 70 percent said they listened most to Radio Uganda (any channel) (see Figure 3.1). Men were more likely than women to listen to Radio Uganda (74 percent *versus* 65 percent), women were more likely than men to listen to Radio Sanyu (16 percent *versus* 10 percent), but there was little gender difference for Capital Radio (men 10 percent, women 11 percent).

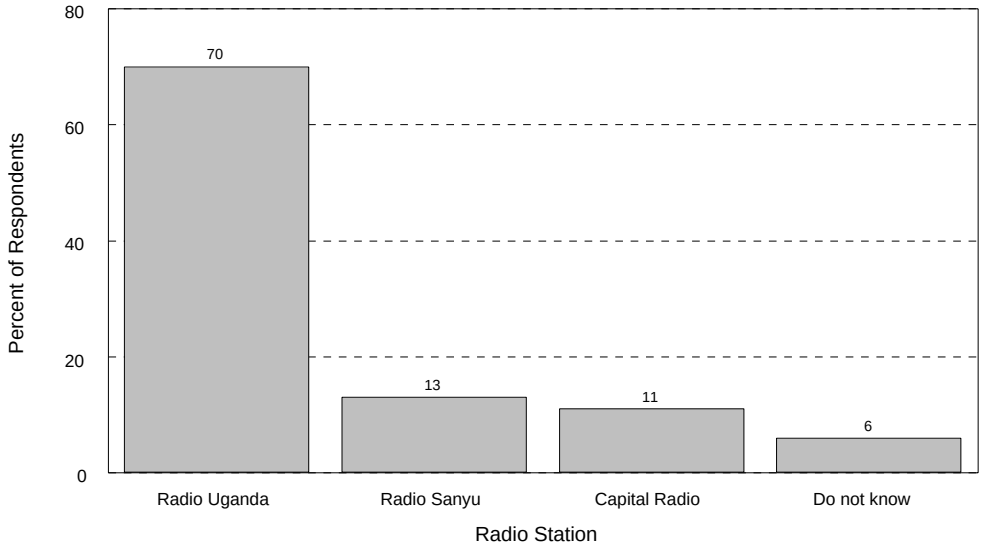
## Exposure to *Capital Doctor* and Protector™ Condom Advertisement

Several months before the launch of the UFPPP, Social Marketing for Change (SOMARC) sponsored a health program, *Capital Doctor*, on Capital Radio. Advertisements for Protector™ condoms were also broadcast on Capital Radio. All respondents who owned or had access to a radio were asked if they had "heard the radio show called *Capital Doctor*," and about 22 percent said they had (see Table 3.5). There was a positive correlation of exposure with education level—only 12 percent of those with no education *versus* 40 percent of those with post-secondary education had heard the program.

**Table 3.5.**
**Percent Distribution of Respondents Who Heard *Capital Doctor* or Protector Condom Ads Among Those Who Own or Have Access to Radio, by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| | *Capital Doctor* | | Protector Condom Ad | |
|---|---|---|---|---|
| | All | Kampala | All | Kampala |
| **Characteristic** | (n=1,165) | (n=279) | (n=1,161) | (n=278) |
| **All** | 21.8 | 49.5 | 62.2 | 78.1 |
| **Gender** | | | | |
| Male | 25.2* | 52.2 | 68.9* | 82.7 |
| Female | 18.4* | 46.5 | 55.7* | 73.6 |
| **Location** | | | | |
| Urban | 22.0 | 48.3 | 63.3 | 78.3 |
| Peri-urban | 21.2 | 52.8 | 59.1 | 77.5 |
| **District** | | | | |

**Figure 3.1.**
**Various Radio Stations Listened to by Respondents from Kampala, Follow-up Survey, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n=279; unadjusted data.

| | | | | |
|---|---|---|---|---|
| Jinja | 8.8* | - | 60.7* | - |
| Masaka | 23.0* | - | 57.1* | - |
| Mbarara | 5.9* | - | 53.5* | - |
| **Education** | | | | |
| None | 12.2* | (40.0) | 41.7* | (40.0)* |
| Primary | 14.4* | 40.0 | 50.1* | 67.1* |
| Secondary | 22.6* | 54.0 | 66.0* | 77.5* |
| Beyond secondary | 36.6* | 54.0 | 66.0* | 77.5* |
| **Age** | | | | |
| 20-24 | 17.6 | 39.1* | 52.9* | 71.0* |
| 25-29 | 26.2 | 65.2* | 63.0* | 72.1* |
| 30-34 | 21.2 | 50.0* | 69.4* | 90.7* |
| 35-40 | 23.3 | 44.8* | 65.8* | 78.5* |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number who answered the question; unadjusted data.
* Demographic differences significant, $p \leq 0.05$.
Percentages in parentheses have a denominator less than 10 respondents, interpret with caution.

Respondents were also asked if they had heard Protector condom ads. No urban / peri-urban differences emerged, but residents of Kampala were the most likely to have heard the ads, and those in Mbarara the least likely. As expected, there was a positive and statistically significant relationship between exposure and education. There was also a positive relationship between age and exposure. Table 3.5 also presents exposure to Protector condom advertisements for Kampala residents only; the Kampala results mirror those for the total sample.

# Chapter IV.
# Family Planning Awareness, Attitudes, and Practices

## Family Planning Awareness

**Source of information**. Respondents were asked what their main source of family planning information was (see Table 4.1). The primary source was radio cited by nearly one-fourth of the respondents. Other main sources were Family Planning Association of Uganda (FPAU) and other clinics and hospitals.

**Table 4.1.**
**Percent Distribution of Respondents by Main Sources of Family Planning Information, Follow-up Survey, Uganda, 1994**

| Source | All (n=1,300) | Men* (n=617) | Women* (n=679) | Urban* (n=961) | Peri-urban* (n=338) |
|---|---|---|---|---|---|
| Radio | 23.6 | 32.4 | 15.5 | 24.1 | 22.2 |
| FPAU and other FP clinics | 18.8 | 13.8 | 23.3 | 17.8 | 21.3 |
| Hospital | 16.0 | 8.4 | 22.8 | 16.1 | 15.7 |
| No particular place | 13.1 | 14.9 | 11.5 | 13.6 | 11.5 |
| Friends | 11.2 | 11.8 | 10.6 | 11.5 | 10.4 |
| Health center | 4.4 | 3.4 | 5.3 | 4.5 | 4.1 |
| CBD/CHW | 4.3 | 4.1 | 4.6 | 4.1 | 5.0 |
| Newspaper | 1.5 | 2.8 | 0.3 | 0.8 | 3.3 |
| Private doctor | 1.4 | 1.1 | 1.6 | 1.4 | 1.5 |
| Other places [a] | 5.7 | 7.3 | 4.5 | 6.1 | 5.0 |
| TOTAL | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: * Differences between male and female sources are significant (p<0.001); differences between urban and peri-urban sources not significant (p =0.131).
[a] Private midwife, pharmacy, shops, work, traditional healer, TV, school seminars, and books, each with less than 1.4 percent of respondents.
Unadjusted data.

There were significant gender differentials—for example, 32 percent of the men cited radio as the primary source of information compared with 16 percent of the women. In contrast, 23 percent of women cited clinics and hospitals as the main source compared with 14 percent of the men (p<0.001). These differences may arise because most female contraceptive methods require contact with a health care provider, and that contact may be more memorable than something heard on radio. Radio was the number one source cited among both urban and peri-urban respondents. There were no statistically significant differences between urban and peri-urban locations in source of information.

**Knowledge**. Respondents were asked to name all the family planning methods they knew. Methods mentioned spontaneously were recorded (spontaneous knowledge). Interviewers then read a brief description of each method not mentioned, and asked if the respondent had heard of it (assisted knowledge). Modern methods included: vasectomy, tubal ligation, Norplant®, pill,

IUD, Depo Provera®, condom, diaphragm, and foaming tablets. Nonmodern methods included safe period, rhythm method, withdrawal, periodic abstinence, breastfeeding, and folk methods.

Results show that the pill and condom were the most commonly known methods, recalled by almost 97 percent of the sample (see Table 4.2). The pill, however, was the more familiar and likely to be recalled spontaneously. In contrast, nearly 40 percent of the sample associated condoms with family planning only after they were described. In general, many respondents recalled some methods only with prompting, suggesting that family planning awareness in Uganda is rather superficial. For example, while only 20 percent could name tubal ligation spontaneously, after prompting, an additional 56 percent said they had heard of it. Some methods remain mostly unknown; for example, more than half the sample said they had not heard of foaming tablets, diaphragm, vasectomy, or Norplant.

**Table 4.2.**
**Percent Distribution of Respondents' Spontaneous and Assisted Knowledge of Specific Contraceptive Methods, by Method: Follow-up Survey, Uganda, 1994**

| Method | Spontaneous Knowledge | Assisted Knowledge | No Knowledge | Total | Sample Size (n) |
|---|---|---|---|---|---|
| Pill | 77.3 | 19.5 | 3.2 | 100.0 | 1,319 |
| Condom | 56.2 | 40.5 | 3.3 | 100.0 | 1,320 |
| Depo-Provera | 47.7 | 38.3 | 14.0 | 100.0 | 1,311 |
| Tubal ligation | 20.3 | 55.6 | 24.1 | 100.0 | 1,313 |
| IUD | 34.6 | 29.8 | 35.6 | 100.0 | 1,310 |
| NFP [a] | 15.8 | 68.2 | 16.0 | 100.0 | 1,316 |
| Foam tablets | 12.3 | 32.8 | 54.9 | 100.0 | 1,313 |
| Diaphragm | 9.4 | 25.9 | 64.7 | 100.0 | 1,306 |
| Vasectomy | 8.6 | 38.2 | 53.2 | 100.0 | 1,310 |
| Periodic abstinence [b] | 7.7 | 61.4 | 30.9 | 100.0 | 1,296 |
| Folk methods | 7.1 | 8.8 | 84.1 | 100.0 | 1,246 |
| Withdrawal | 7.5 | 64.1 | 28.4 | 100.0 | 1,305 |
| Norplant | 6.8 | 20.1 | 73.1 | 100.0 | 1,303 |
| Breast feeding | 6.3 | 67.2 | 26.5 | 100.0 | 1,308 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number of respondents who answered the question; unadjusted data.
[a] Includes postpartum abstinence or prolonged periods of sexual inactivity.
[b] Includes safe period, Billings method, calculation, calendar, and rhythm methods.

**Number of family planning methods known**. Respondents knew an average of 3.2 methods (see Table 4.3). Women knew more methods than men did, especially modern methods. As expected, there was a positive relationship between education and number of methods known. There were no significant age differences.

**Table 4.3.**
**Mean Number of Family Planning Methods Known, by Selected Characteristics,**
**Follow-up Survey, Uganda, 1994**

| Characteristic | Mean Number of Methods Known: All Methods | Modern Methods | Nonmodern Methods | Sample Size (n) |
|---|---|---|---|---|
| **All** | 3.2 | 2.7 | 0.4 | 1,323 |
| **Gender** | | | | |
| Male | 2.8* | 2.3* | 0.4 | 628 |
| Female | 3.5* | 3.1* | 0.4 | 691 |
| **Location** | | | | |
| Urban | 3.1 | 2.6* | 0.4 | 980 |
| Peri-urban | 3.3 | 2.9* | 0.5 | 342 |
| **District** | | | | |
| Kampala | 3.1* | 2.6* | 0.6* | 297 |
| Jinja | 3.7* | 3.1* | 0.6* | 361 |
| Masaka | 2.8* | 2.5* | 0.3* | 369 |
| Mbarara | 3.0* | 2.7* | 0.3* | 295 |
| **Education** | | | | |
| None | 2.1* | 1.8* | 0.3* | 62 |
| Primary | 2.5* | 2.2* | 0.3* | 533 |
| Secondary | 3.5* | 3.0* | 0.5* | 480 |
| Beyond | 4.3* | 3.5* | 0.8* | 246 |
| Secondary | | | | |
| **Age** | | | | |
| 20-24 | 3.0 | 2.6 | 0.4 | 383 |
| 25-29 | 3.3 | 2.8 | 0.5 | 375 |
| 30-34 | 3.4 | 2.9 | 0.5 | 330 |
| 35-40 | 3.0 | 2.5 | 0.5 | 222 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: n is the number who answered the question.
* Demographic differences significant at $p \leq 0.05$.
Unadjusted data.

## Family Planning Attitudes

**Fertility and desired number of children**. On average, respondents had 3.5 children and wanted 1.3 more (see Table 4.4). Men reported having almost one child more than women, perhaps because men in the study were older than women, because of polygamous marriages, or extramarital unions.

Fully 39 percent of the sample desired no more children, and this was especially true among women. Men wanted an average of 5.4 children, whereas women wanted only 4.3 children. Residents of Kampala were the most likely to desire no more children. Of particular interest was the finding that individuals with no formal education were the most likely to want no more children (54 percent), perhaps reflecting the higher parity found in these groups or their economic hardships. As expected, there was a strong negative relationship between desire for additional children and age.

**Table 4.4.**
**Mean Number of Living Children, Additional Children Desired, and Percent of Respondents Desiring No More Children, by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| Characteristic | Mean Number Living | Mean Additional Desired [a] | Percent Desiring No More |
|---|---|---|---|
| **All** | 3.5 | 1.3 | 39.0 |
| **Gender** | | | |
| Male | 3.9* | 1.5* | 35.6* |
| Female | 3.1* | 1.2* | 42.3* |
| **Location** | | | |
| Urban | 3.5* | 1.4 | 39.1 |
| Peri-urban | 3.2 | 1.3 | 38.9 |
| **District** | | | |
| Kampala | 3.4 | 1.0 | 49.7 |
| Jinja | 3.3 | 1.7 | 31.8 |
| Masaka | 3.4 | 1.2* | 40.6 |
| Mbarara | 3.8 | 1.5* | 34.9 |
| **Education** | | | |
| None | 4.2* | 1.0* | 54.2* |
| Primary | 3.8* | 1.5* | 37.3* |
| Secondary | 3.2* | 1.4* | 38.0* |
| Beyond Secondary | 3.2* | 1.1* | 41.2* |
| **Age** | | | |
| 20-24 | 2.0* | 1.8* | 21.8* |
| 25-29 | 2.7* | 1.5* | 30.9* |
| 30-34 | 4.2* | 0.9* | 51.6* |
| 35-40 | 5.6* | 0.9* | 61.7* |
| **Number of Children** | | | |
| 0 - 3 children | 2.0 | 1.6 | 24.7* |
| 4 or more children | 5.7 | 1.1 | 63.3* |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: * Demographic differences significant at $p \leq 0.05$.

[a] Excludes those who gave unquantifiable answers, such as "Up to God" or "don't know/not sure," comprising 6 percent of those who want children. Unadjusted data.

**Attitudes toward family planning**. A number of questions were asked to assess respondents' attitudes toward family planning. A statement was read, and the respondent could agree or disagree with it or remain neutral. The results (see Table 4.5) list the statements and the percentage of positive responses; these data suggest that a substantial minority of men and women are apprehensive about the impact of contraception on marital relations.

An appreciable proportion of the sample also believe that use of family planning will lead to promiscuity. One-fourth fear that men will become more promiscuous, with women significantly more likely to believe this than men ($p \leq 0.001$). One of every five respondents feels that a woman

will become more promiscuous, and men are more likely to believe this than women ($p \leq 0.001$). Thus it appears that each gender is more skeptical of the other than it is of itself.

**Table 4.5.**
**Percent of Respondents Who Agree with Selected Statements about Family Planning, Follow-up Survey, Uganda, 1994**

| Statements | All | Men | Women | Sample Size (n) |
|---|---|---|---|---|
| The practice of FP will cause a loss of confidence between a husband and a wife | 27.0 | 23.9* | 29.9* | 1,317 |
| The practice of FP will bring a couple closer | 70.3 | 69.5 | 70.9 | 1,316 |
| A husband who loves his wife allows her to use FP | 79.7 | 77.1* | 82.2* | 1,280 |
| Use of FP will make a man promiscuous | 25.3 | 22.0* | 28.4* | 1,309 |
| The practice of FP will make a woman promiscuous | 21.8 | 26.4* | 17.6* | 1,309 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number in the total sample who answered the question; unadjusted data.
* Male-female differences significant at $p \leq 0.05$.

Anxiety about fidelity can deter couples from using family planning, since the subject itself may raise suspicion between partners. Such apprehension may make it especially difficult for women, who often have to bear the greater responsibility for securing contraception yet have less power in the sexual dyad. Concerns about faithfulness are further compounded by the AIDS epidemic because infidelity can have deadly consequences.

## Interpersonal Communication and Perceived Support

**Communication with others**. Family planning use can be influenced by the values and beliefs of others. Therefore, a major goal of the UFPPP was to create an environment that supports contraceptive use and to work toward making it a community norm. Respondents were asked whether they had talked to anyone about family planning; those who had were asked if they had talked to a specified list of individuals in the past six months (see Table 4.6).

**Table 4.6.**
**Percent of Respondents Who Talked about Family Planning with Specified Individuals, Follow-up Survey, Uganda, 1994**

| | All (n=1,307) | Men (n=618) | Women (n=685) |
|---|---|---|---|
| Talked to anyone | 74.5 | 70.6* | 78.8* |
| Among those who have talked, person talked to: | | | |
| Spouse | 90.0 | 92.9* | 87.6* |
| Friend | 90.7 | 87.8* | 93.3* |
| Health provider | 64.4 | 58.5* | 69.0* |
| Someone else | 24.2 | 19.1* | 28.3* |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number of respondents who answered the question; Unadjusted data.
* Male-female differences significant at $p \leq 0.05$.

Three-fourths of respondents had talked to someone about family planning, with women more likely to report having done so than men ($p \leq 0.05$). Men were more likely to report having talked to their wives, and women were more likely to report having talked to their friends.

Respondents were also asked if they had ever discussed the number of children they would like to have with their spouses. About 58 percent said they had, 56 percent of the men and 60 percent of the women (p=0.17). There were no differences between urban and peri-urban groups, nor were there variations by district or age group. When grouped by education, however, there were striking differences. Respondents with no education were the least likely to have discussed the number of children (39 percent) while those with post-secondary education were the most likely (77 percent), and the other two groups fell in between: those with primary education at 50 percent, and those with secondary education at 59 percent ($p \leq 0.001$).

**Perceived approval of family planning**. Respondents were asked: "In general, do you think the following would approve or disapprove of your using family planning methods?" A list of individuals was read aloud; the results are shown in Table 4.7.

**Table 4.7.**
**Percent of Respondents Who Think Specified Individuals Would Approve of Use of Family Planning,**
**Follow-up Survey, Uganda, 1994**

| Specified Individual | All | Men | Women | Sample Size (n) |
|---|---|---|---|---|
| Doctor | 85.5 | 84.3 | 86.4 | 1,293 |
| Spouse | 82.3 | 87.6* | 77.5* | 1,313 |
| Closest friend | 79.3 | 74.7* | 83.7* | 1,304 |
| Religion | 61.9 | 61.7 | 62.1 | 1,300 |
| Mother | 57.8 | 49.0* | 65.6* | 1,292 |
| Mother-in-law | 36.8 | 34.4* | 38.8* | 1,289 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number who answered the question; unadjusted data.
* Male-female differences significant at $p \leq 0.05$.

More than 80 percent of the entire sample said doctors and spouses would approve if the respondent were using family planning. Women were less likely than men, however, to think that their spouse would approve of their use of family planning ($p \leq 0.05$). Nearly 80 percent of all those who answered the question felt that their closest friend would approve if the respondent used family planning ($p \leq 0.05$). Clearly there is the perception that family planning is acceptable. Inconsistencies were found in the perceived low level of approval among the religious circles and the older generation. Thus, although individuals might feel supported by spouses and friends in their decision to use contraception, perceived disapproval by elders and religious leaders can deter practice.

## Contraceptive Practices

**Contraceptive use**. Respondents were asked: "Are you or your husband / wife currently doing something or using any method to avoid getting pregnant?" Those who said yes were asked what method they were using; all methods used were recorded. *Only* those who specified the method they or their partners were using were considered family planning users. Based on this definition, almost 42 percent of the 1,323 respondents were using some method of family planning, with the proportions of men and women and of urban and peri-urban residents roughly the same (see Table 4.8).

One notable issue seen in Table 4.8 is the relative constancy of the levels of use of nonmodern methods. Regardless of characteristic, the range between high and low is fairly small—the six-percentage-point difference between Kampala and Jinja Districts being the largest difference. Clearly, nonmodern methods have a strong and stable group of users. Many respondents in the study, however, are candidates for modern contraceptive use.

**Table 4.8.**
**Percent Distribution of Respondents Currently Using Contraceptive Methods, [a]**
**by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| Characteristic | Any Method | Any Modern Method | Any Nonmodern Method | Sample Size (n) |
|---|---|---|---|---|
| **All** | 41.5 | 29.3 | 12.2 | 1,323 |
| **Gender** | | | | |
| Male | 40.9 | 28.2 | 12.7 | 628 |
| Female | 42.0 | 30.1 | 11.9 | 691 |
| **Location** | | | | |
| Urban | 40.9 | 29.4 | 11.5 | 980 |
| Peri-urban | 43.3 | 29.0 | 14.3 | 342 |
| **District** | | | | |
| Kampala | 49.8* | 34.0* | 15.8* | 297 |
| Jinja | 36.0* | 26.3* | 9.7* | 361 |
| Masaka | 46.4* | 32.0* | 14.4* | 369 |
| Mbarara | 33.6* | 24.4* | 9.2* | 295 |
| **Education** | | | | |
| None | 24.2* | 14.5* | 9.7* | 62 |
| Primary | 33.8* | 20.8* | 13.0* | 533 |
| Secondary | 44.1* | 31.0* | 13.1* | 480 |
| Beyond Secondary | 57.7* | 48.0* | 9.7* | 246 |
| **Age** | | | | |
| 20-24 | 34.5* | 21.2* | 13.3* | 383 |
| 25-29 | 41.3* | 29.6* | 11.7* | 375 |
| 30-34 | 46.9* | 34.2* | 12.7* | 330 |
| 35-40 | 46.8* | 36.0* | 10.8* | 222 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number who answered the question; unadjusted data.
* Demographic differences significant at $p \leq 0.05$.
[a] In the case of multiple method use, the most effective method is given priority.

The distribution of reported current method use is presented in Table 4.9. The notable difference between men and women is the greater proportion of men reporting use of condoms and nonmodern methods, while women report greater use of modern methods. This discordance in reporting suggests insufficient communication between men and women on method use and possibly, use outside the union.

Respondents who wanted no more children were more likely to be using contraception than their peers who still desired more children (51 percent *vs.* 36 percent, data not shown). However, 27 percent relied on nonmodern methods. Another 16 percent used short-term methods such as condoms, foaming tablets, and diaphragms.

**Table 4.9.**
**Percent Distribution of Current Contraceptive Users by Methods Used,**
**Follow-up Survey, Uganda, 1994**

| Method | All (n=549) | Men (n=257) | Women (n=290) |
|---|---|---|---|
| Pill | 28.6 | 22.6 | 33.8 |
| Condom | 21.0 | 32.3 | 10.6 |
| Natural family planning | 16.8 | 23.7 | 10.7 |
| Depo-Provera | 14.0 | 10.9 | 16.9 |
| Withdrawal | 10.8 | 14.4 | 7.6 |
| Periodic abstinence | 10.2 | 12.8 | 7.9 |
| Breastfeeding | 9.3 | 7.0 | 11.4 |
| Tubal ligation | 5.3 | 4.3 | 6.2 |
| IUD | 3.6 | 2.7 | 4.5 |
| Norplant | 2.6 | 3.5 | 1.7 |
| Folk methods | 1.8 | 2.3 | 1.4 |
| Diaphragm/Foam tablets | 1.6 | 1.6 | 1.7 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: Unadjusted data; multiple method use possible; n is the number who answered the question.

**Nonusers**. The primary reason for not using family planning was perceived lack of need. Fully 49 percent of the respondents not using family planning either wished to become pregnant, were currently pregnant, or were breastfeeding (see Table 4.10). The second most prevalent reason for not using family planning was perceived lack of access to services or difficulty in obtaining contraceptive supplies. Concerns about side effects was the third most frequently cited reason.

**Table 4.10.**
**Percent Distribution of Nonusers Reporting Reasons for Not Using Family Planning,**
**Follow-up Survey, Uganda, 1994**

| Reason | Primary Reason (n=651) | Secondary Reason (n=92) |
|---|---|---|
| Want child, spouse/self pregnant or breastfeeding | 49.4 | 2.2 |
| No access to family planning/difficult to get supplies | 15.2 | 46.1 |
| Afraid of side effects | 13.8 | 21.0 |
| Spouse opposed | 6.0 | 16.3 |
| Not sexually active | 4.0 | 4.4 |
| Not yet convinced of family planning | 3.5 | 0.0 |
| Forgot to use/cannot follow instructions | 2.0 | 2.0 |
| All others | 6.1[a] | 8.0[b] |
| TOTAL | 100.0 | 100.0 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: [a] Includes: costs too much, doctor recommends not to use, religion, and couple have not discussed, each cited by less than 2 percent of nonusers. [b] Includes: religion, costs too much, and doctor recommends not to use, each cited by less than 3 percent of those who answered.

Unadjusted data.

When asked if they would use family planning in the future, 82 percent of nonusers said they would "probably" or "definitely," 10 percent were not sure, and 8 percent said they would not use. There were no differences in intentions by gender, urban or peri-urban residence, or among the districts. Respondents with no formal education, however, were the most likely to say they would not use (23 percent), compared with those with primary (7 percent), secondary (9 percent) or post-secondary (8 percent) education ($p=0.003$). There was a positive relationship between refusal to use and age, with those in the oldest age group (35 to 40 years) most likely to say they would not use (15 percent), compared with those ages 20 to 24 (4 percent), 25 to 29 (10 percent), and 30 to 34 (9 percent; $p=0.01$).

# Chapter V.
# HIV/AIDS and Other Sexually Transmitted Diseases

## Awareness and Communication with Others

Respondents were asked if they had heard of "diseases that can be transmitted through sex," and nearly all (98 percent) said they had (see Table 5.1). Those who had heard of them were asked to name the diseases they knew. HIV / AIDS and gonorrhea were named most often.

**Table 5.1.**
**Percent Distribution of Respondents by Awareness of STDs, Follow-up Survey, Uganda, 1994**

| Awareness of STDs | All (n=1,285) | Men (n=604) | Women (n=677) | Urban (n=952) | Peri-urban (n=332) |
|---|---|---|---|---|---|
| **Heard of STDs** | 98.4 | 99.1 | 97.8 | 98.2 | 98.8 |
| **STD Named:** | | | | | |
| HIV/AIDS | 84.1 | 85.3 | 82.9 | 82.9* | 87.5* |
| Gonorrhea | 83.3 | 85.6* | 81.4* | 82.8 | 84.5 |
| Syphilis | 70.4 | 71.7 | 69.2 | 68.8* | 75.0* |
| Herpes | 3.4 | 3.9 | 3.0 | 3.0 | 4.6 |
| Candida | 2.6 | 1.7 | 3.5 | 1.8 | 4.9 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number who answered the question; unadjusted data.
* Male/female difference significant at $p \leq 0.05$; Urban/Peri-urban differences significant at $p \leq 0.05$.

Respondents aware of STDs were asked if they had talked to anyone about them. Respondents were more likely to have talked about HIV / AIDS than other STDs (see Table 5.2). Men were, by far, more likely to have talked to someone than were women, especially about other STDs.

**Table 5.2.**
**Percent Distribution of Respondents Who Talked to Others about STDs or HIV/AIDS, by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| Characteristic | HIV/AIDS (n=1,089) | Other STDs (n=1,198) |
|---|---|---|
| **All** | 85.8 | 63.3 |
| **Gender** | | |
| Male | 89.4* | 70.1* |
| Female | 82.3* | 57.1* |
| **Location** | | |
| Urban | 85.6 | 63.6 |
| Peri-urban | 86.2 | 62.2 |
| **Education** | | |
| None | 65.3* | 45.1* |
| Primary | 79.8* | 59.1* |
| Secondary | 91.2* | 63.6* |
| Beyond secondary | 93.6* | 75.5* |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

When asked if respondents would inform their partners if they (the respondent) were found to be infected with HIV / AIDS or another STD, the majority said they would, but they seemed more prepared to do so in the case of STDs other than HIV / AIDS (see Table 5.3). There was a curvilinear association between HIV / AIDS disclosure and education, with the most educated and least educated respondents more likely to say they would inform their partner ($p \leq 0.001$), but there were no educational differences in other STD disclosure.

**Table 5.3.**
**Percent Distribution of Respondents Who Would Inform Partner of Their Infection with HIV/AIDS or Other STDs, by Selected Characteristics,**
**Follow-up Survey, Uganda, 1994**

| Characteristic | HIV/AIDS (n=1,314) | Other STDs (n=1,316) |
|---|---|---|
| **All** | 77.0 | 86.0 |
| **Gender** | | |
| Male | 77.2 | 86.9 |
| Female | 77.0 | 85.3 |
| **Location** | | |
| Urban | 76.5 | 86.2* |
| Peri-urban | 78.3 | 85.4* |
| **District** | | |
| Kampala | 83.1* | 88.9* |
| Jinja | 81.2* | 88.8* |
| Masaka | 61.7* | 81.8* |
| Mbarara | 84.9* | 85.0* |
| **Education** | | |
| None | 83.3* | 83.6 |
| Primary | 72.3* | 84.3 |
| Secondary | 78.2* | 86.9 |
| Beyond Secondary | 83.2* | 88.9 |
| **Age** | | |
| 20-24 | 74.7 | 83.2 |
| 25-29 | 75.3 | 86.7 |
| 30-34 | 78.4 | 86.9 |
| 35-40 | 80.8 | 88.6 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: n is the number who answered each question; unadjusted data.
* Demographic differences significant at $p \leq 0.05$
[a] Possible answers were "yes," "no," and "don't know/not sure."

## Risk Prevention Behavior

Respondents who had heard of STDs (including HIV / AIDS) were asked if they had changed their behavior since learning of these diseases; 77 percent of the 1,252 subjects who responded to both questions said that they had changed their behavior. Men were more likely to report doing so than women (82 percent and 73 percent, respectively; $p \leq 0.001$), perhaps because men were more likely to participate in risk-taking sexual behavior. Those in peri-urban areas were more likely to

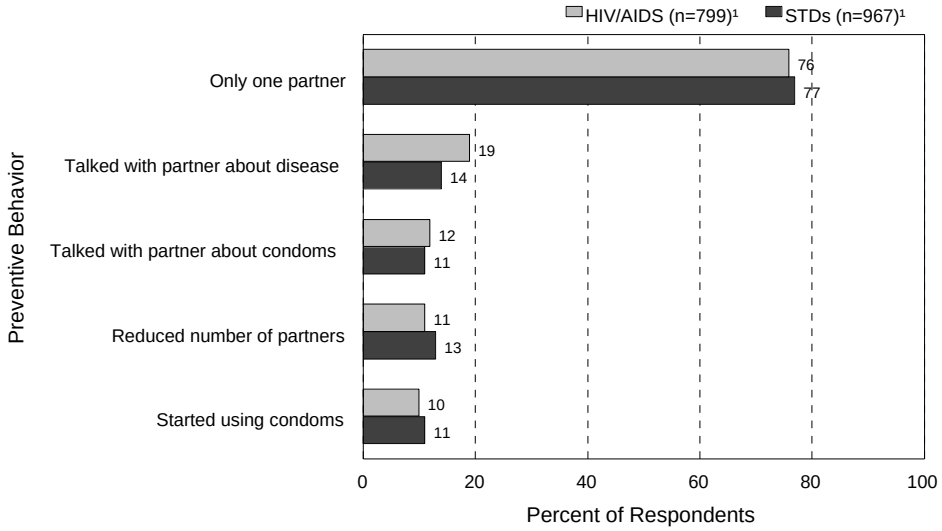
have changed behavior than those in urban areas (82 percent and 75 percent, respectively; $p=0.01$).

There were striking regional differences. Respondents in Mbarara (84 percent) and Jinja (84 percent) were the most likely to have reported behavior change. Those in Masaka were least likely (67 percent) to have reported change, while those in Kampala (74 percent) were in the mid-range. This variation among the districts was statistically significant at $p \leq 0.001$.

There was a positive relationship between education and reported behavior change. Figures ranged from a low of 67 percent among those with no education, to a high of 88 percent among those with post-secondary education ($p \leq 0.001$). There was also a small difference between behavior change based on age—70 percent in the youngest age group had changed, compared with 82 percent of those ages 35 to 40 ($p=0.002$). Thus, respondents in the youngest age group and those with the least education were the least likely to have changed their behavior despite learning of HIV/AIDS and other STDs.

Those who had changed their behavior were asked what action they had taken against HIV/AIDS and then again about other STDs. These were open-ended questions and respondents could mention as many measures as had been taken. The most common preventive measure, both in relation to HIV/AIDS and to other STDs, was limiting sexual relations to one partner (more than three-fourths; see Figure 5.1).

**Figure 5.1.**
**Preventive Behaviors Adopted by Respondents Who Took Action for Each Disease, Follow-up Survey, Uganda, 1994**

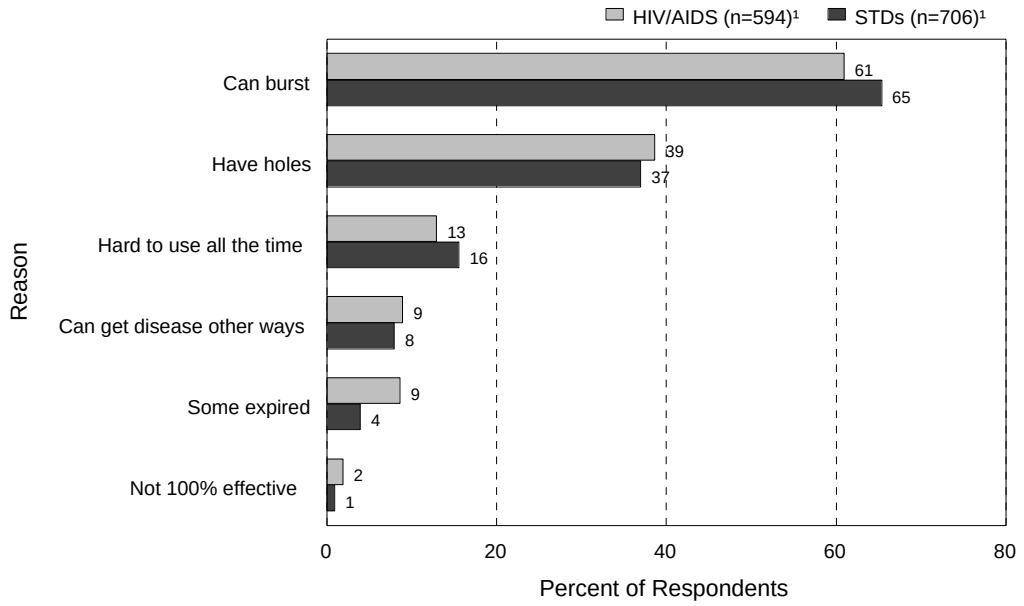



SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: [1] n is the number who knew disease and reported changing behavior.
Unadjusted data.

To assess the perceived level of condom use in the population, respondents were asked whether "most," "some," or "none" of the people they knew used condoms. About 42 percent said "most of them" and 33 percent said "some of them," while 22 percent said they did not know. Considering that only 21 percent of current contraceptive users are using condoms (see Chapter 4), the results suggest people may over-estimate condom use among their peers and that condom use is not yet the social norm.

To explore the opinions regarding condoms and HIV / AIDS prevention, respondents were asked: "Do you think condoms can protect against HIV / AIDS?" The same question was asked of other STDs. Only 60 percent felt that condoms would protect against HIV / AIDS, although more (72 percent) thought that condoms could protect against STDs other than HIV / AIDS. The main reasons for the mistrust of condoms was they could burst or had holes (see Figure 5.2)

**Figure 5.2.**
**Reasons Given by Respondents for Lack of Faith in Condom Protection Against HIV/AIDS and Other STDs Follow-up Survey,Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: ¹ n is the number who knew the disease and said condoms cannot protect against disease.
Unadjusted data.

A major deterrent to consistent condom use in marriage may be its potential for generating mistrust in the relationship. To explore this issue, respondents were asked: "Is it appropriate to use condoms with one's husband / wife to prevent HIV / AIDS and other sexually transmitted diseases?" Approximately 54 percent of the 1,275 respondents who answered the question said it was appropriate. Women were more likely to find condom use appropriate than men (62 percent

*vs.* 46 percent; p<0.001; see Table 5.4). There was a positive relationship between acceptability of condom use and education (p ≤0.001) but a negative one with age (p=0.05).

**Table 5.4.**
**Percent Distribution of Respondents Who Say Condom Use Is Acceptable within Marriage, by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| Characteristic | Actual Number [a] | Percent |
|---|---|---|
| **All** | 690 | 54.1 |
| **Gender** | | |
| Male | 278 | 45.5* |
| Female | 410 | 62.1* |
| **Location** | | |
| Urban | 506 | 53.8* |
| Peri-urban | 184 | 55.1* |
| **District** | | |
| Kampala | 200 | 68.7* |
| Jinja | 210 | 61.6* |
| Masaka | 162 | 45.3* |
| Mbarara | 117 | 41.2* |
| **Education** | | |
| None | 28 | 49.1* |
| Primary | 236 | 46.6* |
| Secondary | 271 | 57.4* |
| Beyond | 153 | 64.6* |
| Secondary | | |
| **Age** | | |
| 20-24 | 197 | 54.0* |
| 25-29 | 213 | 58.0* |
| 30-34 | 177 | 56.0* |
| 35-40 | 99 | 46.3* |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: *Demographic differences significant at p≤0.05.
[a] Number who say condom use is acceptable.
n = 1,275; number who answered the question; unadjusted data.

Some of the reasons given by respondents who found marital condom use appropriate were prevention of infection, spousal distrust, and prevention of pregnancy. Women were statistically more likely than men to cite prevention of infections and spousal distrust. Men were more likely than women to cite pregnancy prevention as a reason to use condoms within marriage (see Table 5.5).

The reasons given by those who found condom use inappropriate are presented in Table 5.5. Men were more likely to cite trusting their partner than women (42 percent *vs.* 30 percent), and women were more likely than men to say that condoms were not reliable (39 percent *vs.* 24 percent). Gender differences were statistically significant.

**Table 5.5.**
**Percent Distribution of Respondents by Condom Use Appropriateness within Marriage,**
**Follow-up Survey, Uganda, 1994**

| Reason | All | Men | Women |
|---|---|---|---|
| **Condom use is appropriate** (n=429)* | | | |
| Prevents infection | 48.3 | 42.1 | 52.6 |
| Prevents pregnancy | 25.6 | 38.6 | 16.6 |
| Does not trust partner | 20.7 | 15.3 | 24.5 |
| For "self protection" | 4.7 | 4.0 | 5.1 |
| Husband polygamous | 0.7 | — | 1.2 |
| TOTAL | 100.0 | 100.0 | 100.0 |
| **Condom use is inappropriate** (n=522)* | | | |
| Trusts partner | 37.2 | 42.2 | 30.2 |
| Method unreliable | 30.5 | 24.2 | 39.2 |
| Unacceptable to partner | 11.5 | 9.7 | 14.0 |
| Promotes immorality | 7.3 | 10.1 | 3.6 |
| Doesn't trust partner | 5.2 | 4.4 | 6.3 |
| Never used/fears them | 4.0 | 5.4 | 2.3 |
| Wants more children | 3.6 | 4.0 | 2.7 |
| Other reasons | 0.7 | 0.0 | 1.7 |
| TOTAL | 100.0 | 100.0 | 100.0 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: * Male/female differences significant at $p \leq 0.05$.
Unadjusted data.

## Risk of HIV/AIDS and HIV/AIDS Testing

Respondents were asked: "What do you think are your chances of getting HIV / AIDS? Are they great, moderate, small, or you cannot really say?" (see Table 5.6). There were clear gender differentials. For example, men were more likely than women to say that their chances were small or none (44 percent *vs.* 33 percent). In contrast, women were more likely than men to consider their risk great (13 percent *vs.* 9 percent) or were more likely to say they did not know (41 percent *vs.* 30 percent). These differences were significant at $p \leq 0.001$.

About one-third (35 percent) of respondents felt that they could not determine their risk of becoming infected with HIV / AIDS. This was particularly true for the youngest respondents and those with lower education—about 40 percent. The fact that such a large proportion of the respondents were uncertain of their risk factors could leave them more vulnerable to infection through unintended risk-taking behavior.

**Table 5.6.**
**Percent Distribution of Respondents' Level of Perceived Risk of HIV/AIDS, by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| Characteristic | Great | Moderate | Small/None | Can't say | Total |
|---|---|---|---|---|---|
| **All** | 10.9 | 15.4 | 38.5 | 35.2 | 100.0 |
| **Gender** | | | | | |
| Male* | 8.5 | 17.5 | 44.4 | 29.6 | 100.0 |
| Female* | 13.0 | 13.6 | 32.9 | 40.5 | 100.0 |
| **Location** | | | | | |
| Urban | 11.0 | 15.0 | 38.4 | 35.6 | 100.0 |
| Peri-urban | 10.8 | 16.7 | 38.9 | 33.6 | 100.0 |
| **District** | | | | | |
| Kampala* | 12.2 | 14.5 | 42.2 | 31.1 | 100.0 |
| Jinja* | 10.5 | 16.1 | 32.1 | 41.3 | 100.0 |
| Masaka* | 6.7 | 18.5 | 39.9 | 34.9 | 100.0 |
| Mbarara* | 12.7 | 11.7 | 42.3 | 33.3 | 100.0 |
| **Education** | | | | | |
| None* | 8.3 | 11.7 | 40.0 | 40.0 | 100.0 |
| Primary* | 9.9 | 15.0 | 35.6 | 39.5 | 100.0 |
| Secondary* | 14.6 | 15.2 | 35.5 | 34.7 | 100.0 |
| Beyond secondary* | 6.2 | 17.6 | 50.8 | 25.4 | 100.0 |
| **Age** | | | | | |
| 20-24 | 13.5 | 12.2 | 36.1 | 38.2 | 100.0 |
| 25-29 | 11.0 | 19.0 | 35.0 | 35.0 | 100.0 |
| 30-34 | 9.8 | 14.0 | 43.3 | 32.9 | 100.0 |
| 35-40 | 9.7 | 14.2 | 41.7 | 34.4 | 100.0 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n=1,311; number who answered the question; unadjusted data.
*Demographic differences significant, $p \leq 0.05$.

To assess the level of high risk behaviors, respondents were asked whether they had sex with anyone other than their spouse in the preceding year. Only five respondents refused to answer this sensitive question. Nevertheless, given the personal nature of the issue, the results should be interpreted with caution. Nearly 20 percent of those who answered the question (33 percent of men and 8 percent of women) said they had an extramarital sexual encounter. About 58 percent

of those who had engaged in extramarital relations said that they or their partner had used a condom during their most recent encounter. Women, Mbarara residents, and those with the least education were least likely to report using condoms at last encounter (see Table 5.7).

The level of condom use is higher among those who had extramarital sex than among the whole study group (21 percent of current contraceptors were using condoms—see Chapter IV). Although a certain amount of acquiescence bias is suspected, condom use is still low—fully 42 percent did not use condoms during their last extramarital encounter.

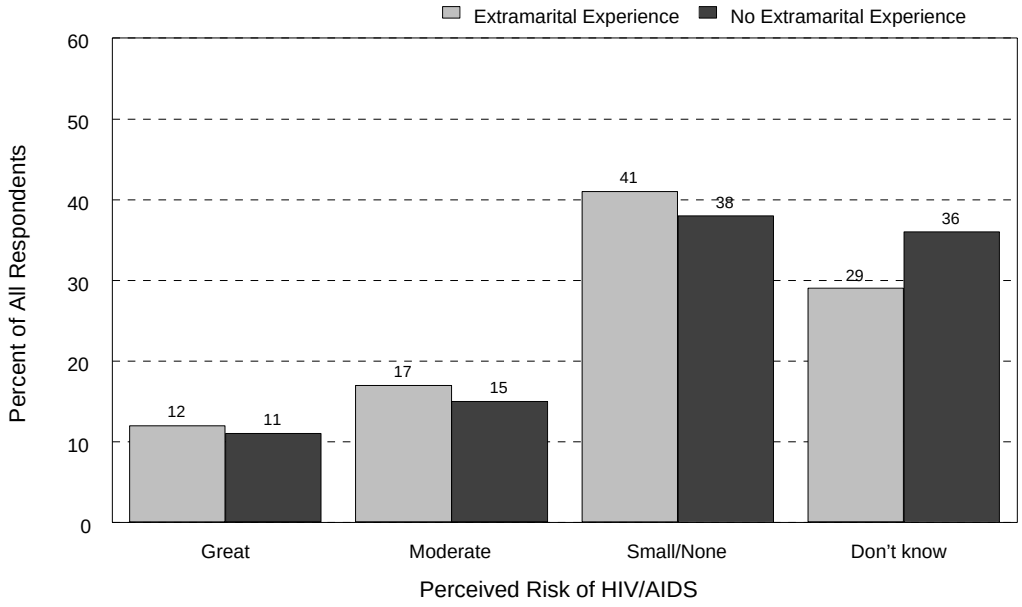
**Table 5.7.**
**Percent Distribution of Respondents, by Extramarital Sex, Condom Use, and HIV/AIDS Testing, by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| Characteristic | Had Extramarital Sex [a] (n=1,308) | Used Condoms at Last Extramarital Sex [b] (n=243) | Tested for HIV/AIDS: Reported Extramarital Sex (n=257) | Tested for HIV/AIDS: All Respondents (n=1,313) |
|---|---|---|---|---|
| **All** | 19.7 | 58.0 | 22.5 | 18.3 |
| **Gender** | | | | |
| Male | 33.1* | 61.9* | 21.1 | 20.2 |
| Female | 7.6* | 43.8* | 28.9 | 16.5 |
| **Location** | | | | |
| Urban | 18.7 | 56.5 | 22.7 | 18.3 |
| Peri-urban | 22.5 | 61.6 | 23.4 | 18.2 |
| **District** | | | | |
| Kampala | 13.9* | 55.0* | 17.1 | 21.0 |
| Jinja | 18.4* | 59.4* | 28.8 | 18.2 |
| Masaka | 25.0* | 68.3* | 16.5 | 15.8 |
| Mbarara | 20.0* | 42.9* | 27.6 | 18.5 |
| **Education** | | | | |
| None | 18.0 | 9.1* | 9.1 | 11.5* |
| Primary | 18.6 | 45.1* | 16.3 | 13.6* |
| Secondary | 21.4 | 66.7* | 26.5 | 19.9* |
| Beyond secondary | 18.6 | 78.1* | 31.1 | 27.2* |
| **Age** | | | | |
| 20-24 | 14.6* | 68.5 | 23.6 | 15.7 |
| 25-29 | 21.8* | 58.4 | 23.5 | 19.8 |
| 30-34 | 23.7* | 52.2 | 21.8 | 20.3 |
| 35-40 | 18.4* | 57.5 | 22.5 | 17.3 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number who answered the question; unadjusted data.
*Demographic differences significant at $p \leq 0.05$.
[a] In the past year.
[b] Condom use by respondent or partner. Reported as percentages of those who had extramarital sex in past year.

Analysis of the relationship between extramarital sexual experience and perceived risk of HIV/AIDS revealed that those who had reported having extramarital sex were no more likely to consider themselves at greater risk of HIV/AIDS than those who had not had extramarital sex (see Figure 5.3). There were apparent differences in the way men and women perceived their

**Figure 5.3.**
**Respondents' Perceived Risk of HIV/AIDS, by Extramarital Sexual Experience in the Past Year, Follow-up Survey, Uganda, 1994**

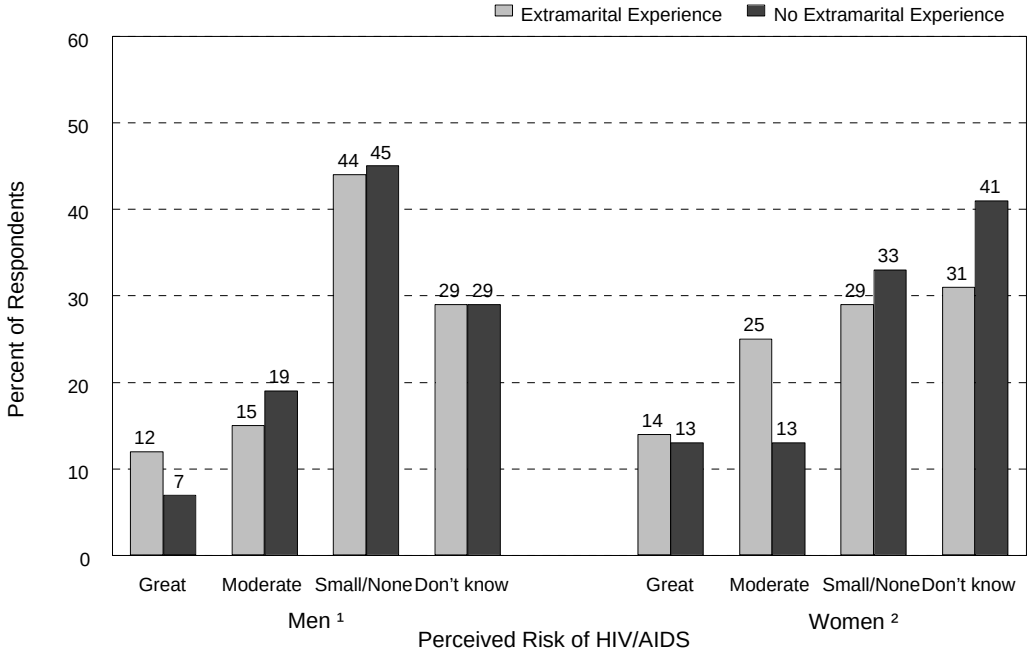



SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTE: n=1,300; Differences in perceived risk by extramarial experience not significany at p=0.203
Unadjusted data

risk of HIV/AIDS; women were more likely to consider themselves at greater risk of HIV/AIDS if they had engaged in extramarital relations (p=0.07). Men, in contrast, were no more likely to consider themselves at additional risk than if they had not engaged in extramarital relationships (p=0.175; see Figure 5.4).

All respondents were asked whether they had been tested for HIV/AIDS. About 23 percent of those who had extramarital relations had been tested for HIV/AIDS compared with 18 percent of the entire sample (see Table 5.7). There were no significant differences within the various demographic groups except for a slight positive relationship between testing and education (p=0.10). Although these differences are not statistically significant, they do indicate that men and women engaging in similar activities perceive their risks differently.

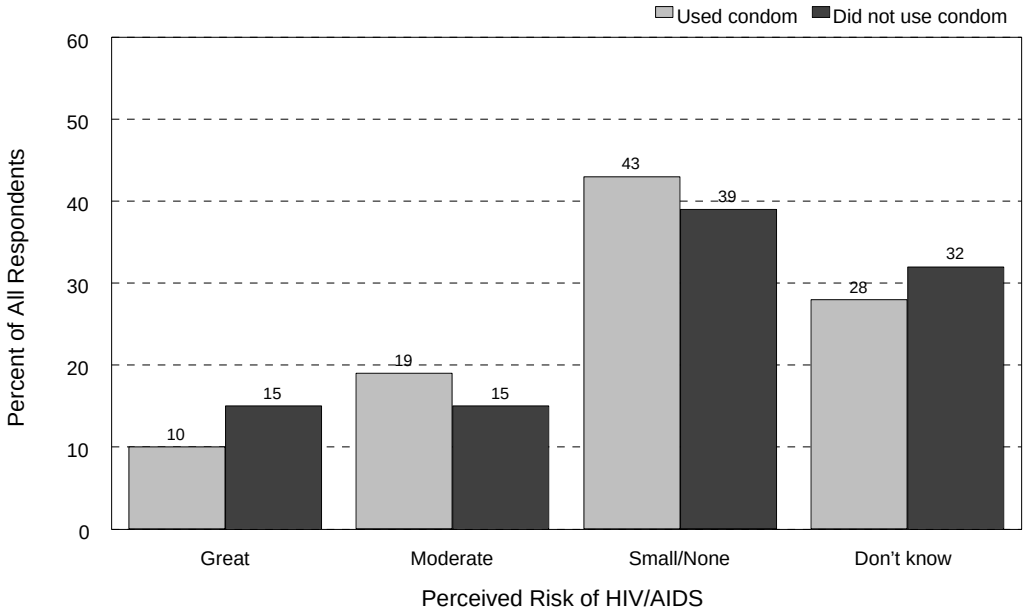
**Figure 5.4.**
**Respondents' Perceived Risk of HIV/AIDS, by Gender and Extramarital Sexual Experience in the Past Year, Follow-up Survey, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: Unadjustd data.
[1] n=616; p=0.165
[2] n=680; p=0.07

The relationship between extramarital condom use and perceived risk of HIV / AIDS is presented in Figure 5.5. Those who had not used a condom at last extramarital intercourse were no more likely to consider themselves at greater risk of HIV / AIDS than those who had (p=0.485). There were differences by gender, however—women who had not used condoms at their last extramarital intercourse were almost twice as likely as their using counterparts to consider themselves at elevated risk (data not shown). Men, in contrast, were no more likely to consider themselves at risk by not using condoms. Although these differences were not statistically significant, they suggest a difference in risk perception between men and women.

**Figure 5.5.**
**Respondents' Perceived Risk of HIV/AIDS, by Condom Use During Last Extramarital Experience, Follow-up Survey, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n=242;
Differences in perceived risk by condom use at last extramarital experience not significant at p=0.485; unadjusted data.

Of those who had not yet been tested for HIV / AIDS, 63 percent would consider being tested (see Table 5.8). Women were more likely to consider testing than men (69 percent *vs.* 58 percent; $p<0.001$). There was an inverse relationship between desire for testing and both education and age. Approximately 85 percent of those who had not been tested knew where they could go for a test. Places mentioned included both public and private hospitals and clinics, The AIDS Support Organization, the AIDS Information Center at Baumann House, and the Virus Research Institute.

**Table 5.8.**
**Percent Distribution of Respondents Not Tested for HIV/AIDS Who Would Consider Testing and Percent Who Knew Where to Go, by Selected Characteristics,**
**Follow-up Survey, Uganda, 1994**

| Characteristic | Would Consider Testing (n=1,073) | Knew Where to Go for Testing (n=900) |
|---|---|---|
| **All** | 63.4 | 85.3 |
| **Gender** | | |
| Male | 57.6* | 88.4* |
| Female | 68.5* | 82.7* |
| **Location** | | |
| Urban | 64.8 | 85.9 |
| Peri-urban | 59.2 | 83.8 |
| **District** | | |
| Kampala | 60.5 | 82.4* |
| Jinja | 65.5 | 80.3* |
| Masaka | 60.4 | 88.3* |
| Mbarara | 67.4 | 89.8* |
| **Education** | | |
| None | 68.5* | 69.4* |
| Primary | 67.8* | 82.3* |
| Secondary | 58.7* | 90.1* |
| Beyond secondary | 60.0* | 88.1* |
| **Age** | | |
| 20-24 | 70.8* | 84.4 |
| 25-29 | 63.4* | 87.0 |
| 30-34 | 59.6* | 83.0 |
| 35-40 | 56.9* | 86.7 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number who answered the questions; unadjusted data.
*Demographic differences significant at $p \leq 0.05$.

## Family Planning and HIV/AIDS

Although it has been suggested that use of birth control pills could hypothetically increase the likelihood of HIV/AIDS infection, this question is still debated, and further study is necessary to resolve this issue. To explore the extent of fear of acquiring HIV/AIDS through the use of birth control pills, respondents were read the statement: "Birth control pills increase the risk of getting HIV/AIDS." Possible answers were "true," "false," or "don't know." Eighteen percent of the respondents believed this statement to be true, 46 percent responded "false," and 36 percent did not know (see Table 5.9). Women, expected to have more knowledge of the pill, were more likely than men to believe it was false, but only by 8 percentage points.

**Table 5.9.**
**Percent Distribution of Responses to the Statement, "Birth Control Pills Increase the Risk of HIV/AIDS," by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| | Response to Statement | | | |
|---|---|---|---|---|
| **Characteristic** | **True** | **False** | **Don't Know** | **Total** |
| **All** | 17.5 | 46.3 | 36.2 | 100.0 |
| **Gender*** | | | | |
| Male | 18.3 | 42.0 | 39.7 | 100.0 |
| Female | 16.7 | 50.3 | 33.0 | 100.0 |
| **Location*** | | | | |
| Urban | 17.6 | 45.8 | 36.6 | 100.0 |
| Peri-urban | 17.1 | 48.2 | 34.7 | 100.0 |
| **District*** | | | | |
| Kampala | 26.5 | 39.8 | 33.7 | 100.0 |
| Jinja | 15.0 | 59.9 | 25.1 | 100.0 |
| Masaka | 12.7 | 46.1 | 41.2 | 100.0 |
| Mbarara | 17.5 | 36.3 | 46.2 | 100.0 |
| **Education*** | | | | |
| None | 11.7 | 45.0 | 43.3 | 100.0 |
| Primary | 16.5 | 42.1 | 41.4 | 100.0 |
| Secondary | 16.8 | 51.2 | 32.0 | 100.0 |
| Beyond secondary | 22.3 | 46.7 | 31.0 | 100.0 |
| **Age** | | | | |
| 20-24 | 18.3 | 51.7 | 30.0 | 100.0 |
| 25-29 | 15.9 | 44.2 | 39.9 | 100.0 |
| 30-34 | 16.7 | 46.5 | 36.8 | 100.0 |
| 35-40 | 19.6 | 41.6 | 38.8 | 100.0 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n=1,305; unadjusted data.
*Demographic differences significant at $p \leq 0.05$.

# Chapter VI.
# Other Reproductive Health Topics

## Breastfeeding

**Practice**. To assess the prevalence of breastfeeding in the community, respondents with children were asked if their most recent child had been breastfed. Among the 918 respondents who answered this question, 86 percent said their youngest child had been breastfed, and the average duration of breastfeeding was 14 months (see Table 6.1).

**Table 6.1.**
**Percent Distribution of Respondents Who Breastfed Youngest Child, and Mean Actual and Mean Ideal Duration of Breastfeeding, by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| Characteristic | Breastfed Youngest Child (percent) (n=918) | Mean Actual Duration of Breastfeeding (months)[a] (n=786) | Mean Ideal Duration of Breastfeeding (months) (n=1,239) |
|---|---|---|---|
| **All** | 86.4 | 14.3 | 18.7 |
| **Gender** | | | |
| Male[b] | 85.0 | 14.2 | 17.5* |
| Female | 87.5 | 14.4 | 19.7* |
| **Location** | | | |
| Urban | 87.8 | 14.1 | 18.9* |
| Peri-urban | 82.8 | 14.9 | 18.0* |
| **District** | | | |
| Kampala | 95.0* | 14.9* | 19.1* |
| Jinja | 83.9* | 13.3* | 17.9* |
| Masaka | 67.8* | 13.2* | 19.1* |
| Mbarara | 97.8* | 15.3* | 18.6* |
| **Education** | | | |
| None | 79.1 | 16.0 | 19.3 |
| Primary | 86.5 | 14.4 | 19.0 |
| Secondary | 85.3 | 13.7 | 18.3 |
| Beyond secondary | 90.0 | 14.7 | 18.5 |
| **Age** | | | |
| 20-24 | 85.9 | 13.2 | 19.3* |
| 25-29 | 86.5 | 13.8 | 18.1* |
| 30-34 | 85.7 | 14.7 | 18.7* |
| 35-40 | 87.4 | 15.1 | 18.1* |

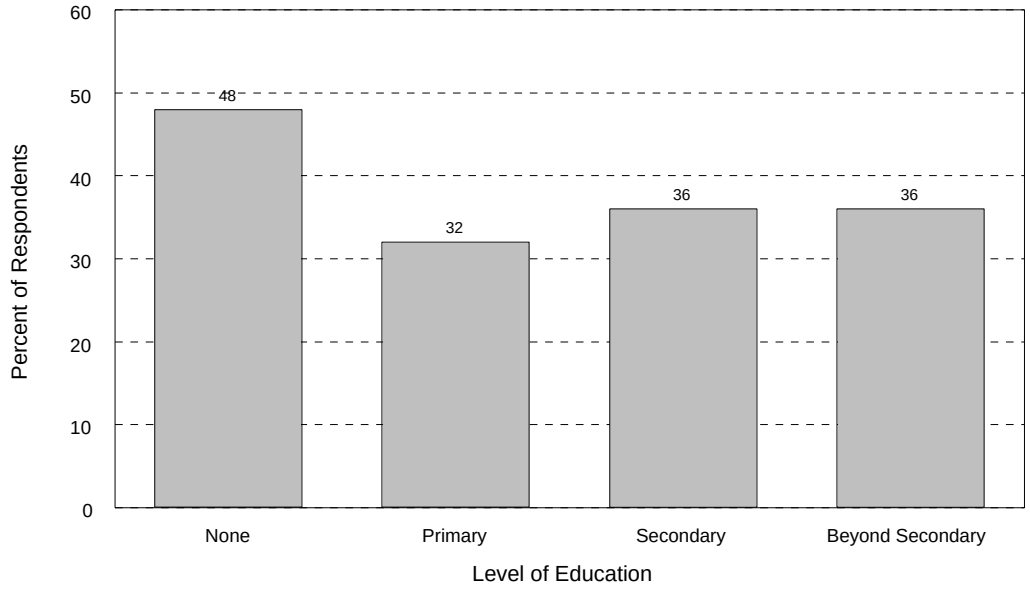
SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number who answered the question; unadjusted data.
* Demographic differences significant at $p \leq 0.05$.
[a] Excludes those still breastfeeding (30 percent) and can't recall (4 percent).
[b] Response refers to female spouse/partner.

There were regional variations in the likelihood of breastfeeding and breastfeeding duration. On the whole, respondents favored prolonged breastfeeding and suggested that a woman should

ideally breastfeed for 18.7 months. Of interest was the result that younger respondents recommended a longer duration of breastfeeding than older respondents (p=0.03).

**Breastfeeding and birth control pills**. To assess the public's knowledge of the relationship between breastfeeding and use of oral contraceptives, respondents were read the following statement: "It is not safe for a breastfeeding woman to use a family planning pills." Response options were "true," "false," and "don't know." The question did not attempt to ascertain to whom the safety issue referred; therefore, their answers could refer to the safety of the mother or the infant. Of all respondents, 28 percent said the statement was true, 35 percent said it was false, and 36 percent said they did not know (data not shown). Women were more likely than men to say that the statement was false (23 percent *vs.* 45 percent; p<0.01). There were no differences between urban and peri-urban respondents (p=0.57), nor were there significant variations by district (p=0.43). Respondents with the least education were the most likely to feel that it would be safe for a breastfeeding women to use oral contraceptives (p=0.03) (see Figure 6.1). There were no statistically significant differences by age groups (p=0.07).

**Figure 6.1.**
**Respondents Who Believe It Is Safe for Breastfeeding Women to Use Oral Contraceptives, by Level of Education, Follow-up Survey, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTE: n=1,298; unadjusted data; p=0.03

## Abortion

**Awareness and source**. Abortion is illegal in Uganda except in cases of saving the life of the mother or of fetal deformity. It is, however, not uncommon—a review of medical records in four

major hospitals (New Mulago and Nsambya Hospitals in Kampala, Jinja Provincial Hospital in Jinja, and Masaka Hospital in Masaka) estimates there are over 5,000 annual admissions for incomplete abortions. (Kinoti *et al.*, 1994).

Follow-up survey respondents were asked if they knew someone who had an abortion, and nearly 63 percent said they did (see Table 6.2). There was a positive relationship between education and abortion—those with post-secondary education were most likely to know someone who had one ($p \leq 0.05$). While these responses are not indicative of prevalence, they do suggest that abortion is practiced and is widely known.

**Table 6.2.**
**Percent of Respondents Who Knew Someone Who Had Had an Abortion, by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| Characteristic | Percent |
|---|---|
| **All** | 62.7 |
| **Gender** | |
| Male | 62.8 |
| Female | 62.6 |
| **Location** | |
| Urban | 61.8 |
| Peri-urban | 65.0 |
| **District** | |
| Kampala | 59.3* |
| Jinja | 57.3* |
| Masaka | 64.4* |
| Mbarara | 70.5* |
| **Education** | |
| None | 49.2* |
| Primary | 55.4* |
| Secondary | 64.9* |
| Beyond secondary | 77.8* |
| **Age** | |
| 20-24 | 62.0 |
| 25-29 | 62.5 |
| 30-34 | 64.4 |
| 35-40 | 60.3 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n =1,310; unadjusted data.
* Demographic differences significant at $p \leq 0.05$.

**Sources for an abortion**. Respondents were asked where a woman would go to get an abortion if she wanted one. They could give more than one answer. Hospitals were cited most frequently. Other providers included private doctors, traditional healers, and private nurses/midwives. About 10 percent of the sample said they did not know where one could obtain an abortion (see Table 6.3).

**Table 6.3.**
**Percent of Respondents Reporting Perceived Sources of Abortion, Follow-up Survey, Uganda, 1994**

| Source | Number | Percent |
|---|---|---|
| Hospital | 706 | 53.4 |
| Private doctor | 461 | 34.9 |
| Traditional healer | 227 | 17.2 |
| Private nurse | 80 | 6.1 |
| Other places | 56 | 4.2 |
| Refused | 31 | 2.3 |
| Friend | 12 | 0.9 |
| Pharmacist | 9 | 0.7 |
| Don't know/not sure | 133 | 10.1 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion (1992-1994).
NOTE: Unadjusted data; multiple responses possible.

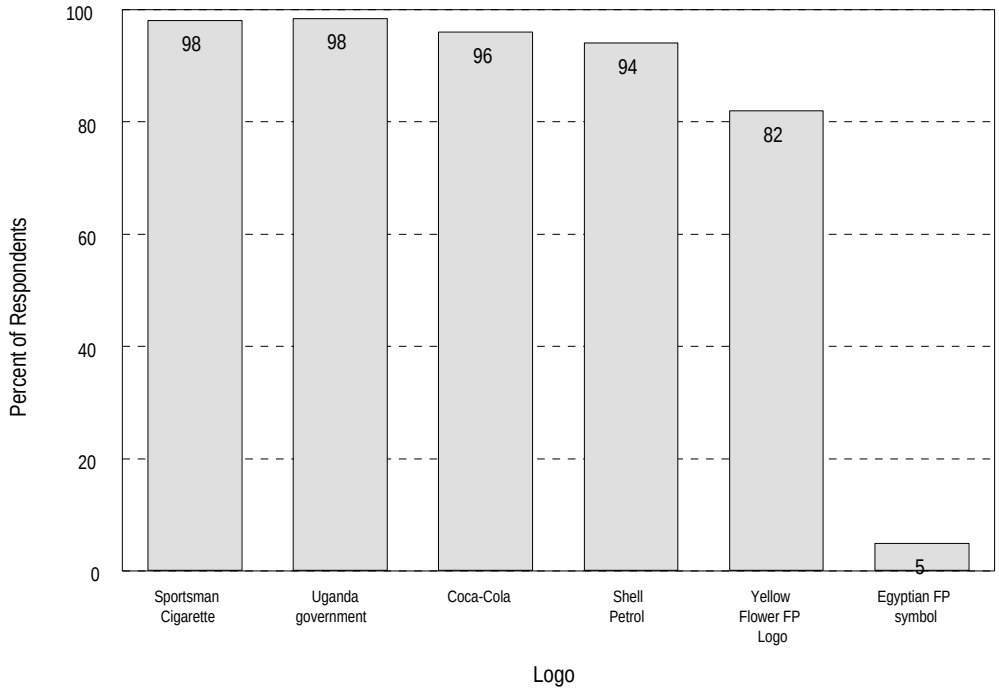
# Chapter VII.
# Evaluation of the Uganda Family Planning Promotion Project

## Exposure to Campaign Materials

**Yellow Flower family planning logo**. An objective of the Uganda Family Planning Promotion Project (UFPPP) was to develop and publicize a family planning logo (see front cover) that would provide a national symbol to help coordinate family planning activities and publicize locations where both women and men could obtain services or advice. To assess exposure to the Yellow Flower logo, respondents were shown a template of common logos and asked if they had seen each one. The logos included the Coca-Cola logo, the Uganda government coat of arms, Sportsman brand cigarettes, Shell petroleum, the Yellow Flower family planning logo, and, as a control, the Egyptian family planning logo (see Figure 7.2). About 82 percent of respondents said they had seen the Yellow Flower family planning logo (see Figure 7.1). Such a significant proportion of reported exposure attests to the logo's successful distribution and publicity, with anecdotal reports placing it in the most remote villages.

Respondents who said they had not seen the Yellow Flower were asked if they had heard about it; an additional 4 percent of the sample said they had. This raised overall logo exposure to 86 percent (see Table 7.1).

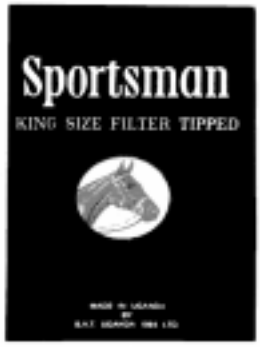
**Figure 7.1.**
**Recognition of Various Logos,**
**Follow-up Survey, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTE: n=1,323; unadjusted data.

**Figure 7.2.**
**Template of the Logos Shown for Recognition, Follow-up Survey, Uganda, 1994**


Uganda Government Coat of Arms




Sportsman Cigarettes


Shell Petroleum

**Table 7.1. Percent Distribution of Respondents Exposed to the Yellow Flower Logo and Percent Who Knew Its Meaning Among Those Exposed, by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| Characteristic | Exposed to Logo (n=1,323) | Knew Meaning of Logo[a] (n=1,074) |
|---|---|---|
| **All** | 85.6 | 95.7 |
| **Gender** | | |
| Male | 87.6* | 94.9 |
| Female | 83.8* | 96.7 |
| **Location** | | |
| Urban | 84.2* | 95.7 |
| Peri-urban | 89.8* | 96.0 |
| **District** | | |
| Kampala | 85.5 | 96.1* |


Uganda Family Planning logo


Coca-Cola logo


Egyptian Family Planning logo

SOURCE: JHU/CCP & FPAU

| | | |
|---|---|---|
| Jinja | 85.9 | 98.3* |
| Masaka | 87.8 | 96.1* |
| Mbarara | 82.7 | 91.7* |
| **Education** | | |
| None | 58.1* | 87.9* |
| Primary | 78.6* | 94.6* |
| Secondary | 91.5* | 97.2* |
| Beyond secondary | 96.3* | 96.1* |
| **Age** | | |
| 20-24 | 81.2* | 96.6 |
| 25-29 | 86.7* | 96.8 |
| 30-34 | 88.8* | 96.1 |
| 35-40 | 86.9* | 92.9 |

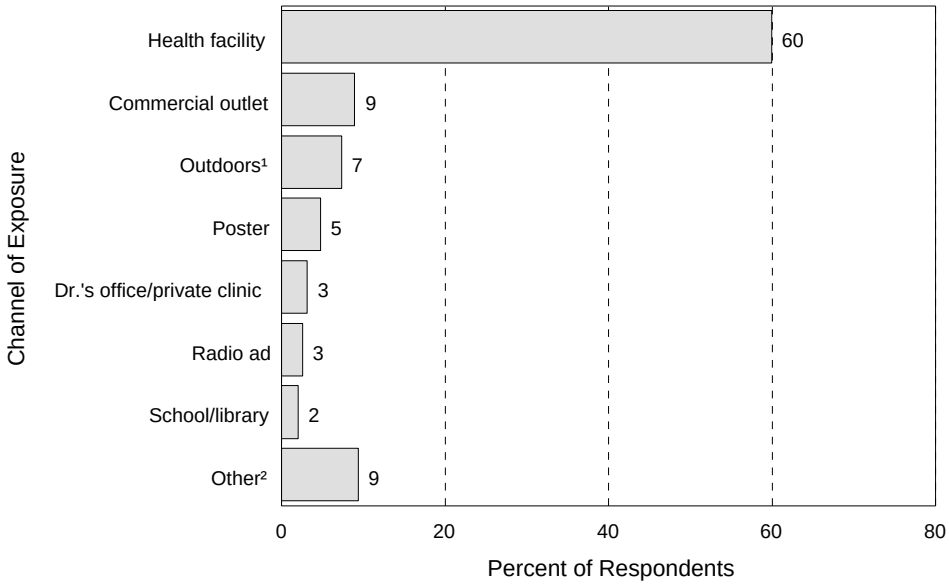
SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: n is the number who answered the question.
* Demographic differences significant at $p \leq 0.05$.
[a] Among those who have been exposed to logo.
Unadjusted data.

Nearly all (96 percent) who had been exposed to the logo were able to explain its meaning correctly (see Table 7.1). Accurate logo interpretation was so high that, even in the group with the lowest level of recognition (those with the least education), 88 percent could correctly explain the meaning of the Yellow Flower. These levels, however, might be expected given the amount of publicity the logo received.

Those who had seen or heard about the logo were asked where they had been exposed to it (see Figure 7.3). More than half of the respondents reported seeing the logo in one of several health facilities (hospital, health center, or family planning clinic). Nine percent saw it at a commercial outlet, such as a chemist's shop, while a small number saw it "outdoors," in public areas where other business advertisements are placed.

**Figure 7.3.**
**Channels of Exposure to Yellow Flower Logo, Follow-up Survey, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n=1,017; unadjusted data; multiple responses possible.
¹ Includes nonspecific channels of exposure such as "all over," "everywhere," etc.
² Includes billboards, pamphlets, radio drama, at home, and other places, each with less than 2 percent of responses.

***Konoweeka* radio drama**. When respondents were asked whether they had heard the radio drama, *Konoweeka*, which was broadcast as part of the UFPPP, nearly 26 percent had heard it (see Table 7.2). *Konoweeka* aimed to convey a number of messages, including the importance of couple communication about family planning, the economic benefits of family planning, the role of men in family planning, and information about contraceptive side effects. In addition, the drama publicized the newly launched Yellow Flower family planning logo.

Respondents who had heard *Konoweeka* were asked what important messages they could recall from it (spontaneous recall); all messages mentioned by the respondents were recorded. For each key message not recalled, a description of the message was read, and the respondent was asked whether he/she recalled hearing it (assisted recall). Among those who had listened to the show, 67 percent could recall at least one of the main messages spontaneously (see Table 7.2). There were district variations in message recall, but there were no other major differences among the remaining subgroups.

**Table 7.2.**
**Percent Distribution of Respondents Who Heard *Konoweeka* and Percent Who Could Spontaneously Recall a Message (Among Those Who Heard), by Selected Characteristics, Follow-up Survey, Uganda, 1994**

| Characteristic | Heard *Konoweeka* (n=1,323) | Heard *Konoweeka* and Could Spontaneously Recall a Message (n=346) |
|---|---|---|
| **All** | 26.2 | 67.3 |
| **Gender** | | |
| Male | 26.7 | 70.3 |
| Female | 31.1 | 64.7 |
| **Location** | | |
| Urban | 26.6 | 65.5 |
| Peri-urban | 27.0 | 72.9 |
| **District** | | |
| Kampala | 34.7* | 73.4* |
| Jinja | 19.6* | 86.9* |
| Masaka | 34.5* | 63.8* |
| Mbarara | 26.0* | 46.4* |
| **Education** | | |
| None | 32.7 | 68.8 |
| Primary | 30.4 | 61.2 |
| Secondary | 28.1 | 74.6 |
| Beyond secondary | 26.6 | 67.2 |
| **Age** | | |
| 20-24 | 28.4 | 66.3 |
| 25-29 | 29.9 | 66.0 |
| 30-34 | 27.7 | 65.5 |
| 35-40 | 29.4 | 71.7 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number who answered the question; unadjusted data.
* Demographic differences significant at $p \leq 0.05$.

Among those who had heard the program, 97 percent could recall at least one message after prompting (see Table 7.3). The messages most frequently recalled spontaneously were those about method safety and the economic benefits of family planning, by 37 percent and 35 percent of the audience, respectively. Most of the other messages were recalled after prompting. Clearly, *Konoweeka* was able to communicate many of its messages.

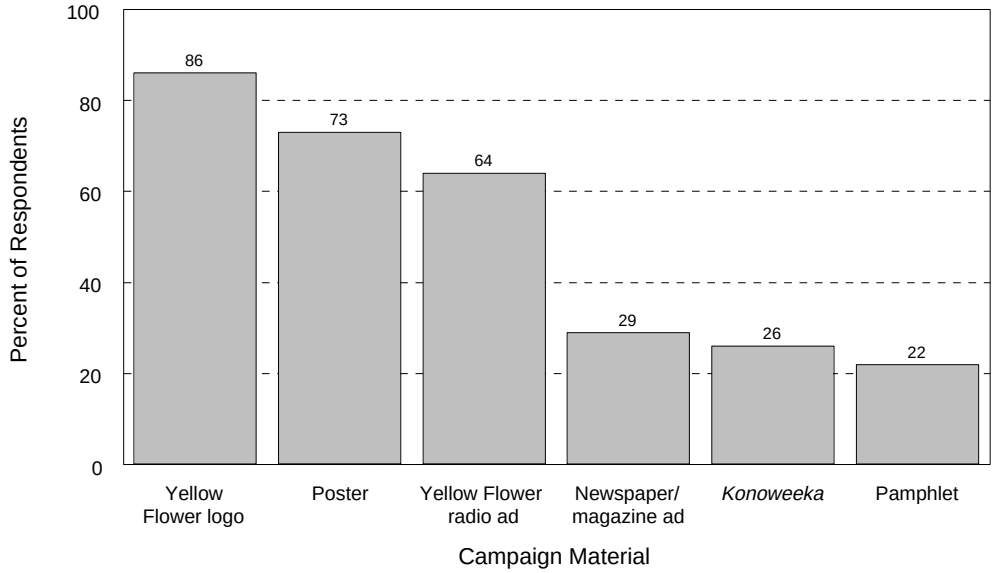
**Table 7.3.**
**Percent Distribution of Respondents Exposed to *Konoweeka* by Recall of Specific Messages, Follow-up Survey, Uganda, 1994**

| Recalled Message | Spontaneous Recall | Assisted Recall | Assisted and Spontaneous Recall | Sample size (n) |
|---|---|---|---|---|
| Family planning can improve economic situation | 36.5 | 59.4 | 95.9 | 337 |
| Family planning methods are safe and reliable | 35.0 | 57.0 | 92.0 | 337 |
| Couples should use family planning | 28.6 | 67.5 | 96.1 | 335 |
| Men should learn about family planning | 25.7 | 64.9 | 90.6 | 339 |
| Wherever you see the Yellow Flower, you can get family planning services | 20.7 | 69.2 | 89.9 | 338 |
| Family planning means having desired number of children | 21.1 | 63.8 | 84.9 | 337 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTE: n is the number who answered the question; unadjusted data.

**Overall exposure to other campaign materials**. In addition to being questioned about logo and radio drama exposure, respondents were shown the campaign poster and pamphlet and asked if they had seen each one in the preceding six months. They were also asked if they had seen information about family planning in the newspaper or heard the Yellow Flower advertisement on radio. About 92 percent said they had been exposed to at least one of the campaign materials. Pamphlet exposure, however, was low (22 percent)—an expected result since pamphlets are found mostly in health care establishments (see Figure 7.4).

**Figure 7.4**
**Campaign Materials Seen or Recalled**
**Follow-up Survey, Uganda, 1994**

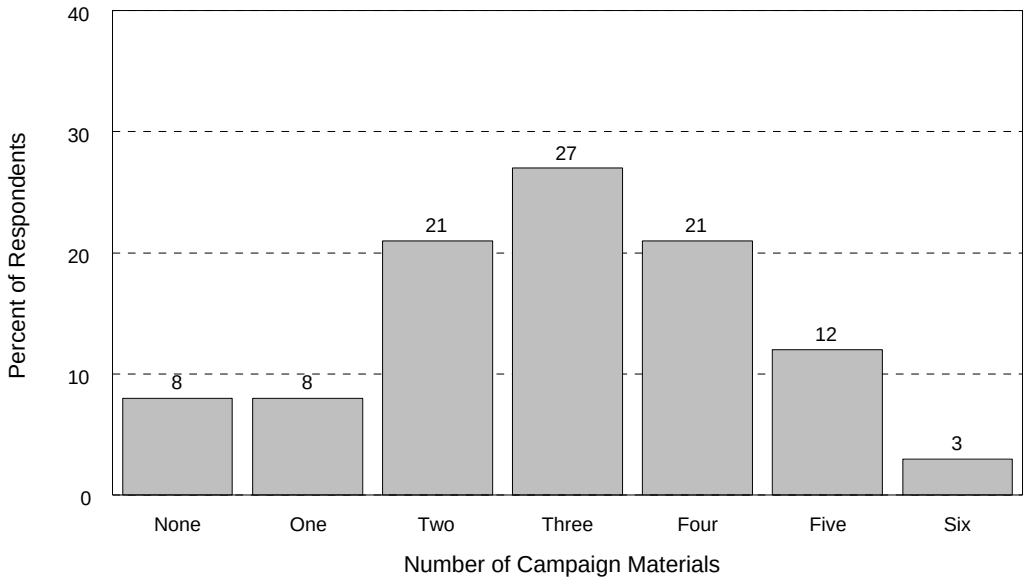



SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTE: Sample size varies by number answering question; unadjusted data.

A respondent could have been exposed to a total of six IEC materials during the campaign. Figure 7.5 shows the percent distribution of materials recalled. Only 8 percent were not exposed to any material. Therefore, 92 percent of the sample had been exposed to one or more products of the campaign.

Respondents had been exposed to a mean of 2.9 materials, with no difference between men and women or between urban and peri-urban residents (data not shown). There was a significant difference in exposure by education ($p<0.001$). Respondents with no formal education were exposed to an average of two materials, and those with post-secondary education were exposed to 3.5 materials. There were also differences by age. The youngest respondents had the least exposure (2.7 materials), while those ages 30 to 34 had the most exposure, at 3.1 materials ($p=0.004$). Variations by districts were consistent with expectations: that is, respondents in Kampala reported the greatest exposure (3.2 materials), followed by those in Jinja and Masaka (2.9 materials each) and in Mbarara (2.7 materials) ($p=0.0001$).

**Figure 7.5.**
**Number of Campaign Materials Seen or Recalled, Follow-up Survey, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTE: n=1,323; unadjusted data.

## Project Impact: Evidence from the Household Surveys

**Standardizing the data**. The follow-up survey used the same sampling procedures and was designed by the same team as the baseline survey. Nevertheless, data analysis revealed that the two samples differed in important ways (see Table 7.4):

- **Gender**—The follow-up survey had a larger proportion of men;
- **Urban/peri-urban—**The follow-up survey had a larger proportion of peri-urban respondents;
- **Education**—The follow-up survey had larger numbers of less educated respondents;
- **Age structure**—The follow-up survey had a higher proportion of younger respondents;

**Table 7.4.**
**Percent Distribution of Baseline and Follow-up Respondents, by Selected Characteristics, Baseline and Follow-up Surveys, Uganda, 1992-1994**

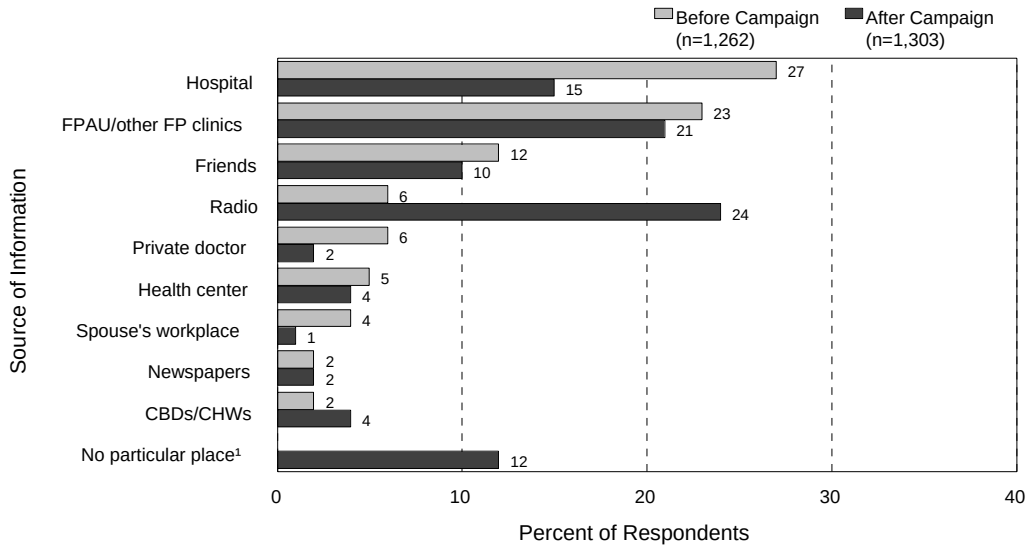
| | Baseline Survey (n=1,347) | | Follow-up Survey (n=1,323) | | |
|---|---|---|---|---|---|
| **Characteristic** | **Number** | **Percent (100.0)** | **Number** | **Unadjusted Percent (100.0)** | **Adjusted Percent (100.0)** |
| **Gender*** | | | | | |
| Male | 700 | 52.0 | 628 | 47.6 | 52.5 |
| Female | 647 | 48.0 | 691 | 52.4 | 47.5 |
| **Location*** | | | | | |
| Urban | 1,064 | 79.1 | 980 | 74.1 | 79.6 |
| Peri-urban | 281 | 20.9 | 342 | 25.9 | 20.4 |
| **District*** | | | | | |
| Kampala | 333 | 24.7 | 297 | 22.5 | 25.7 |
| Jinja | 328 | 24.4 | 361 | 27.3 | 27.3 |
| Masaka | 366 | 27.2 | 369 | 27.9 | 28.8 |
| Mbarara | 319 | 23.7 | 395 | 22.3 | 18.2 |
| **Education*** | | | | | |
| None | 54 | 4.0 | 62 | 4.7 | 3.7 |
| Primary | 384 | 28.5 | 533 | 40.4 | 28.0 |
| Secondary | 529 | 39.3 | 480 | 36.3 | 40.0 |
| Beyond secondary | 380 | 28.2 | 246 | 18.6 | 28.3 |
| **Religion*** | | | | | |
| Protestant | 553 | 41.1 | 519 | 39.2 | 40.2 |
| Catholic | 530 | 39.4 | 489 | 37.0 | 37.5 |
| Muslim | 254 | 18.9 | 301 | 22.8 | 20.9 |
| Traditional/Other/None | 8 | 0.6 | 14 | 1.0 | 1.4 |
| **Age*** | | | | | |
| 20-24 | 258 | 19.2 | 383 | 29.2 | 19.6 |
| 25-29 | 405 | 30.1 | 375 | 28.6 | 30.1 |
| 30-34 | 402 | 29.8 | 330 | 25.2 | 30.3 |
| 35-40 | 282 | 20.9 | 222 | 17.0 | 20.0 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: Totals may not add up to sample size due to missing data. * Baseline and follow-up differences significant at $p \leq 0.05$.

Anecdotal evidence also suggests that the follow up survey had a larger proportion of lower socio-economic status respondents. In order to compare the two surveys it was essential to adjust one of the data sets. The baseline data set was chosen as the standard. The follow-up survey was adjusted to match the baseline survey with respect to gender, age, urban or peri-urban residence, and education. [3] Essentially, this technique involves a recalculation of the population distribution of the follow-up survey, accomplished by assigning variable weights to the respondents. The process is called indirect standardization (Armitage and Berry, 1987). *Whenever baseline and follow-up survey results are compared, adjusted follow-up data must be used.* When follow-up data are discussed on their own, unadjusted data are used, as has been the case in this report up to this point.

**Source of family planning information**. Before the campaign, only 6 percent of the sample cited radio as their main source of family planning information, but during the campaign, 24 percent cited radio as their main source, exceeding hospitals, clinics, and friends as sources. The gains were particularly notable among men. Initially, 7 percent of men reported radio as their primary source, but during the campaign, this number rose to 32 percent. Women continued to get their information primarily from hospitals and clinics, but those citing radio more than doubled, rising from 6 percent to 16 percent during the intervention (see Figures 7.6-7.8).

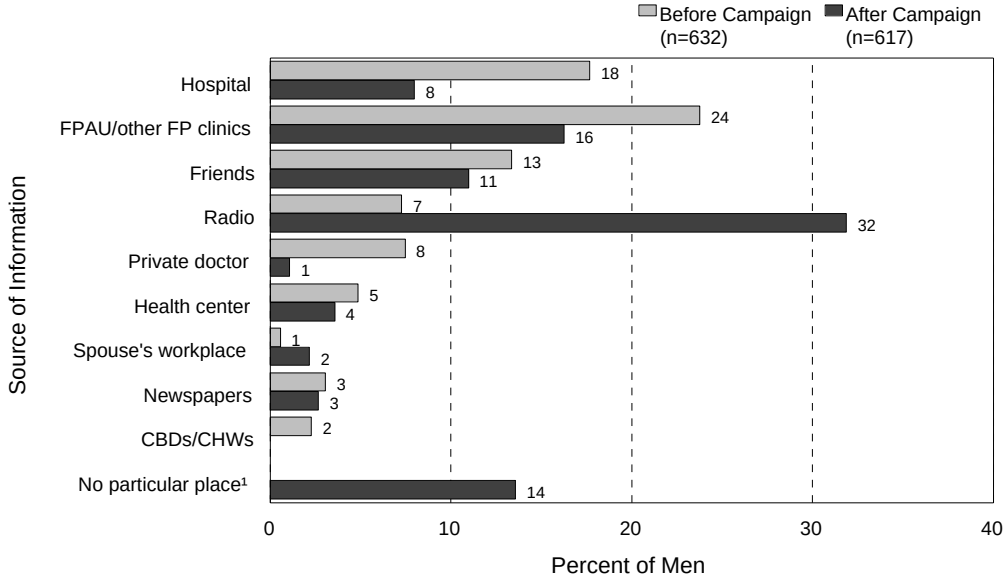
**Figure 7.6.**
**Respondents' Main Source of Information on Family Planning Methods, Before and After the Campaign, Baseline and Follow-up Surveys, Uganda, 1992 and 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: Adjusted follow-up data.
Totals do not add up to 100 percent because responses reported by less than 1 percent are not included.
¹ Data not collected in baseline survey.

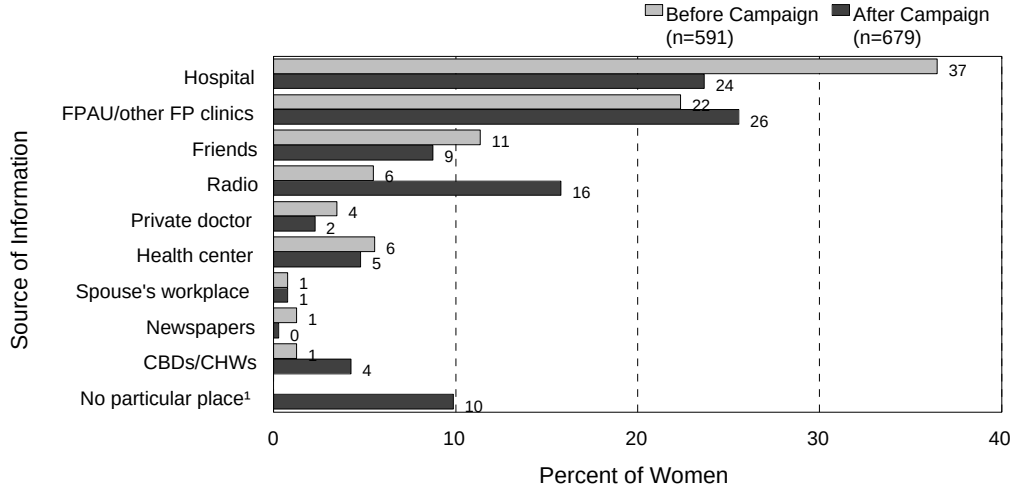
[3] The sample distribution of the baseline survey was applied to the follow-up survey data by developing a series of weights. All adjustment variables were cross-tabulated to obtain the weight for each cell. The weights were calculated as follows:
Cell weight (W)= B / F; where B= baseline cell size; F= follow-up cell size.

**Figure 7.7.**
**Men's Primary Source of Information on Family Planning Methods, Before and After the Campaign, Baseline and Follow-up Surveys, Uganda, 1992 and 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: Adjusted follow-up data.
Totals do not add to 100 percent because responses reported by less than 1 percent were not included.
¹ Data not collected in baseline survey

**Figure 7.8.**
**Women's Primary Source of Information on Family Planning Methods, Before and After the Campaign, Baseline and Follow-up Surveys, Uganda, 1992 and 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: Adjusted follow-up data.
Totals do not add up to 100 percent because responses reported by less than 1 percent are not included.
¹ Data not collected in baseline survey.

**Fertility—additional children desired**. The campaign emphasized the drawbacks of a large, unplanned family and encouraged couples to adopt contraception and limit their fertility to avoid the hardships associated with large families. Evaluation results suggest that the message had the desired impact—data show a marked increase in the percentage of respondents who desired no additional children, from 38 percent before the campaign to 43 percent after the campaign (see Table 7.5). This was especially the case among women, those from peri-urban areas, those in Kampala, those with no education or with primary education, and those in the youngest age groups. It is important to note that the proportion of those with no formal education who did not want more children doubled during the follow-up survey and exceeded those of other groups. This also was the group with the highest exposure to the radio program (see Table 7.2).

**Table 7.5.**
**Percent Distribution of Respondents Who Want No More Children, Before and After the Campaign, by Selected Characteristics, Uganda, 1992 and 1994**

| Characteristic | Before Campaign (n=1,347) | After Campaign[a] (n=1,323) |
|---|---|---|
| **All** | 37.7* | 43.3* |
| **Gender** | | |
| Male | 35.1* | 39.8* |
| Female | 40.5* | 47.4* |
| **Location** | | |
| Urban | 39.1 | 43.6 |
| Peri-urban | 32.4 | 42.2 |
| **District** | | |
| Kampala | 36.6* | 54.7* |
| Jinja | 34.8 | 36.3 |
| Masaka | 39.9 | 44.6 |
| Mbarara | 39.5 | 35.4 |
| **Education** | | |
| None | 29.6* | 60.6* |
| Primary | 32.9* | 41.7* |
| Secondary | 37.5* | 42.8* |
| Beyond secondary | 43.7 | 43.4 |
| **Age** | | |
| 20-24 | 11.6* | 22.5* |
| 25-29 | 32.6 | 32.2 |
| 30-34 | 45.8* | 53.4* |
| 35-40 | 57.5 | 63.0 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: * Pre- and post-campaign differences significant at $p \leq 0.05$.
[a] Adjusted follow-up data.

**Attitudes toward family planning**. Reactions to a number of attitudinal statements were analyzed to compare respondents' attitudes toward family planning before and after the campaign. These attitudes had been largely favorable even before the campaign and that may explain why they did not improve substantially. For example, while 88 percent of the baseline respondents felt that if a husband loved his wife, he would allow her to use family planning, 80 percent felt the same way during the follow-up survey ($p<0.001$). Despite this decline, the

majority of respondents in both surveys felt that husbands who loved their wives would not prevent them from using contraception. Likewise, the majority of respondents agreed that family planning would bring a couple closer together, even though this did not rise during the campaign. Before the campaign, 72 percent agreed with this statement, while after the campaign 70 percent agreed. The percent of respondents who were undecided increased from 9 percent to 13 percent ($p<0.001$).

Concerns about family planning and marital infidelity remained. For instance, while 68 percent of baseline respondents did not agree that family planning would lead to *female* promiscuity, this figure dropped to 62 percent at follow-up. In fact, the percent agreeing with the statement rose from 16 percent to 21 percent ($p=0.001$). At the same time, while 63 percent of baseline respondents did not agree that family planning would lead to *male* promiscuity, this declined to 58 percent at follow-up. The percent agreeing rose from 17 percent at the baseline to 25 percent at the follow-up ($p<0.001$). In contrast, while 56 percent of baseline respondents did not agree that contraception would lead to a loss of trust between husband and wife, this figure rose to 59 percent at follow-up ($p=0.02$). Although this last increase improved slightly, fears connecting family planning with loss of marital trust persist and should be addressed.

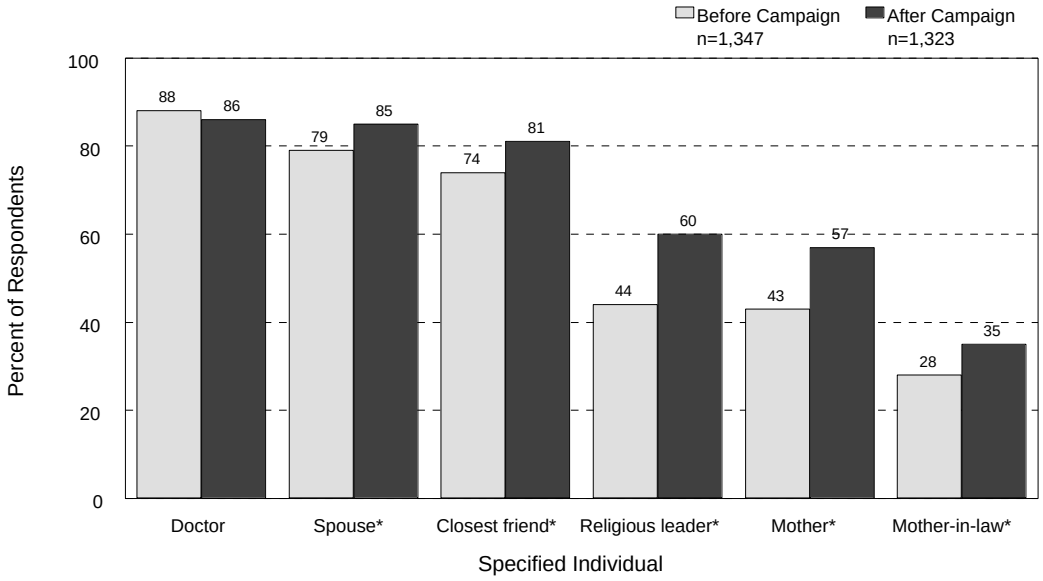
**Approval of family planning**. Family planning use can be strongly influenced by the perceived support of those close to the user, such as family and friends. The UFPPP campaigns therefore addressed not only potential users, but also those who could provide social or political support. For example, the male-motivation component of the campaign encouraged men to support their wives in the use of family planning.

To find out whether the campaign was associated with improvement in perceived approval from others, the baseline and adjusted follow-up survey results were compared (see Figure 7.9). Respondents were asked: "Would any of the following approve of your using family planning?" A list of individuals was then read with possible answers being "yes," "no," and "don't know."

There was a significant increase in the proportion who felt that their spouses would approve if the respondents used contraception ($p< 0.001$). Men registered more gains than did women—some 83 percent of men perceived approval by their wives before the campaign. This group increased to 90 percent during the campaign ($p< 0.001$). Gains among women were less impressive but were still significant—75 percent of wives perceived approval by their husbands before the campaign, 79 percent did so during the campaign ($p< 0.001$). Respondents were also more likely to report approval of their closest friend ($p< 0.001$).

The most gains appear to have been made in the perceived approval of religion, mothers, and mothers-in-law. Those reporting religious approval rose from 44 percent before the campaign to 60 percent after ($p< 0.001$). Men and women registered similar increases. Those reporting approval from their mothers rose ($p< 0.0001$) and again men registered sharper rises—from 35 percent before the campaign to 47 percent after. Perceived approval for mothers-in-law also rose from 28 percent to 35 percent ($p< 0.001$). Although these increases are encouraging, the majority of men and women still fear maternal disapproval of contraception.

**Figure 7.9.**
**Respondents Who Believe Specified Individual Would Approve of Family Planning Use, Before and After the Campaign, Baseline and Follow-up Surveys, Uganda, 1992 and 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: Adjusted follow-up data.
*Pre-/post-campaign differences significant at p<0.05.

**Family planning use**. As discussed in Chapter IV, for each contraceptive method a respondent knew, he or she was asked if he or she (or a partner) had ever used it. About 80 percent of baseline respondents said they had ever used a method, compared with 77 percent at follow-up (standardized data). Respondents were defined as current users if they indicated that they (or their spouses) were currently doing something to avoid conception, and the method they were using. Based on this definition, 50 percent[4] of the respondents were users during the baseline compared with 46 percent at follow-up (standardized data; p=0.02).

Contraceptive users were then classified as using modern or nonmodern methods (see Table 7.6). Among current users of any method, the proportion using modern methods rose from 69 percent to 74 percent (p=0.03). The proportion using a modern method, except IUD and female sterilization, rose. The proportion using nonmodern methods remained the same.

The highest gains were in condom use, which increased its share of the method mix by almost one-third. In addition to the UFPPP, this increase could also be attributed to greater availability of condoms through field educators as well as the promotion of condoms to prevent HIV/AIDS and other STDs. The increase in withdrawal use may also be related to fear of HIV/AIDS— anecdotal

[4] See Kiragu et al. (1993) for baseline survey results

evidence suggests that individuals may think that reducing the amount of bodily fluids exchanged reduces the risk of infection.

**Table 7.6.**
**Percent Distribution of Current Users by Methods Used Before and After the Campaign, Baseline and Follow-up Surveys, Uganda, 1992 and 1994**

| Family Planning Method[a] | Before Campaign (n=679) | After Campaign (n=549) |
|---|---|---|
| **Any Modern Method** | 68.5 | 74.1* |
| Pill | 29.3 | 32.0 |
| Condom | 16.8 | 22.5* |
| Depo-Provera | 12.1 | 13.8 |
| IUD | 10.6 | 4.9* |
| Female sterilization | 8.4 | 5.0* |
| Male sterilization | 0.4 | 0.0* |
| Diaphragm/Foam/Jelly | 0.4 | 1.2 |
| Norplant | 0.2 | 2.7* |
| **Any Nonmodern Method** | 39.0 | 37.6 |
| Natural Family Planning | 21.4 | 18.5 |
| Breastfeeding | 10.8 | 7.0* |
| Periodic abstinence | 10.6 | 8.3 |
| Withdrawal | 5.3 | 11.1* |
| Folk methods | 2.2 | 2.1 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: * Pre- and post- campaign differences significant at $p \leq 0.05$. Adjusted follow-up data.

Modern method use rose, particularly among women and peri-urban residents (see Table 7.7). Although the campaign was not associated with a gain in overall contraceptive use, some switched from nonmodern to modern method use.

**Table 7.7.**
**Percent Distribution of Respondents Currently Using Modern or Nonmodern Methods, by Selected Characteristics, Before and After the Campaign, Baseline and Follow-up Surveys, Uganda, 1992 and 1994**

| Characteristic | Modern Methods | | Nonmodern Methods | |
|---|---|---|---|---|
| | Before Campaign | After Campaign | Before Campaign | After Campaign |
| **All family planning users** | 68.5 | 74.1* | 39.0 | 37.6 |
| **Gender** | | | | |
| Male | 70.8 | 73.4 | 39.2 | 43.6 |
| Female | 65.8 | 74.6* | 38.9 | 31.2* |
| **Location** | | | | |
| Urban | 70.7 | 75.9 | 37.1 | 37.0 |
| Peri-urban | 57.3 | 66.1 | 49.1 | 40.5 |
| **Education** | | | | |
| None | 40.0 | 71.2* | 73.3 | 28.8* |
| Primary | 47.5 | 64.1* | 56.2 | 41.8* |
| Secondary | 71.8 | 72.4 | 35.4 | 36.6 |
| Beyond secondary | 78.1 | 81.9 | 31.6 | 36.7 |
| **Age** | | | | |
| 20-24 | 34.5 | 61.6* | 72.4 | 44.7* |

| | | | | |
|---|---|---|---|---|
| 25-29 | 73.4 | 76.0 | 35.3 | 33.8 |
| 30-34 | 71.2 | 74.3 | 31.2 | 40.4 |
| 35-40 | 76.5 | 79.8 | 36.5 | 33.3 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: * Pre- and post-campaign differences significant at $p \leq 0.05$. Adjusted follow-up data.

**Campaign exposure and family planning use**. The follow-up survey sought to examine whether people who had been exposed to the campaign were more likely to use family planning compared with those who had not been exposed.[5] (Because there are no pre-/post-campaign comparisons, the results are based on the unadjusted follow-up data.) While causality cannot be established using cross-sectional data such as these, the results demonstrate a clear association between campaign exposure and family planning use (see Table 7.8). Those who had seen the Yellow Flower logo were almost twice as likely to be using family planning as those who had not seen it. Exposure to other campaign materials, except for the radio drama, was uniformly associated with greater use of *any* method and *modern* methods. For example, those who had seen the logo were almost three times as likely to use a modern family planning method as those who had not. The more materials an individual was exposed to, the greater the likelihood of use. This pattern was consistent for both modern and nonmodern methods.

[5] Exposure was defined by ability to *recall* specific campaign materials. This definition may underestimate true exposure, since some people who saw the materials may not recall them and are thus classified as unexposed.

**Table 7.8.**
**Percent of Respondents Currently Using Contraceptive Methods, by Campaign Exposure, Follow-up Survey, Uganda, 1994**

| Exposure | Use Any Method | Use Modern Method | Use Nonmodern Method |
|---|---|---|---|
| **All** | 41.5 | 27.1 | 17.8 |
| **Seen Yellow Flower Logo?** | | | |
| Yes | 44.5* | 29.9* | 18.2 |
| No | 23.7* | 10.8* | 14.7 |
| **Heard Radio Drama?** | | | |
| Yes | 44.5 | 31.0 | 16.7 |
| No | 42.0 | 27.0 | 18.6 |
| **Seen Poster?** | | | |
| Yes | 47.4* | 31.6* | 20.0* |
| No | 25.6* | 15.3* | 11.8* |
| **Seen Pamphlet?** | | | |
| Yes | 54.4* | 40.0* | 19.6 |
| No | 38.2* | 23.7* | 17.4 |
| **Seen FP Information in Newspaper?** | | | |
| Yes | 48.6* | 34.1* | 19.9 |
| No | 38.4* | 23.8* | 17.3 |
| **Heard Yellow Flower Ad?** | | | |
| Yes | 45.2* | 29.8 | 19.0 |
| No | 38.3* | 25.3 | 16.3 |
| **Number of materials exposed** | | | |
| 0-1 materials | 20.0* | 10.9* | 9.1* |
| 2-4 materials | 44.0* | 25.9* | 18.1* |
| 5-6 materials | 54.1* | 37.2* | 16.8* |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: n=1,323; unadjusted data.
*Exposed and unexposed differences significant at $p \leq 0.05$.

**Multivariate logistic regression analysis**. Because family planning use is greatly influenced by factors other than campaign exposure, logistic regression analysis was performed to examine the relationship between campaign exposure and contraceptive use. Logistic regression is a statistical technique that allows the simultaneous examination of the influence of many factors on behavior. This technique also allows one to control the influence of confounding variables, variables that would otherwise interfere with the relationships being examined (Kelsey *et al.*, 1986). For example, because education is strongly related to both contraceptive use *and* the likelihood of being exposed to the campaign, it would be essential to control for education to see the independent impact of the campaign on contraceptive use.

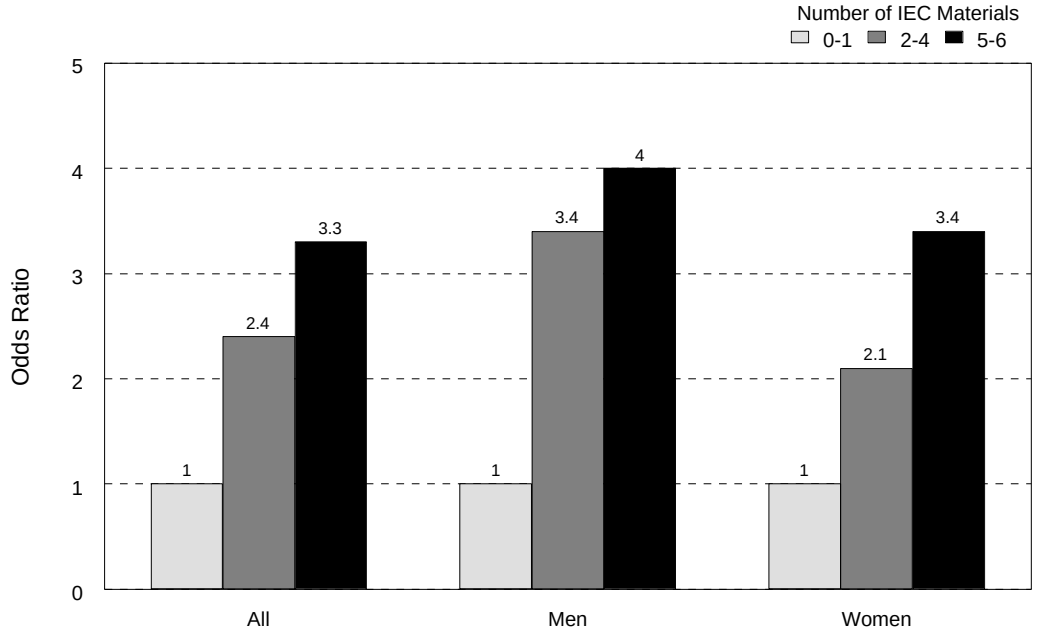
The UFPPP evaluation examined the impact of the campaign, controlling for education, age, number of children, attitudes toward family planning, ownership of a radio, a television, a car, urban / peri-urban residence, and the resident district. These allowed for assessment of the relationship between campaign exposure and contraceptive behavior, regardless of these variables.

The measure of association used in logistic regression is the odds ratio. The odds ratio compares the likelihood of observing an outcome among persons exposed to a specific factor of interest compared with those not exposed. For example, in this evaluation the odds ratio was used to examine the likelihood of contraceptive use for a respondent who was exposed to the campaign *versus* the likelihood for a person not exposed. In interpreting the odds ratio, one group must be selected as a reference, and all others are compared with it. The odds ratio is presented as values above, below, or equal to 1.00. Values above 1.00 indicate that persons with the factor are more likely to use contraceptives than persons in the reference group. Values below 1.00 suggest that persons with the factor are less likely to use than those in the reference group. Values close to 1.00 suggest there is no substantial difference between the two groups.

Data show that campaign exposure was associated with the use of *any* contraceptive method as well as the use of a *modern* method (see Figures 7.10-7.13 and Appendix II). The association was stronger among men than among women. For example, men exposed to only two to four campaign materials were more than three times as likely to use a family planning method. Only after women had been exposed to five to six materials were they more than three times as likely to use. Campaign exposure also was associated with the use of modern family planning methods. Individuals who had been exposed to two to four materials were nearly twice as likely to use modern methods as those exposed to one or none; those exposed to five to six materials were nearly three times as likely (see Figure 7.11).

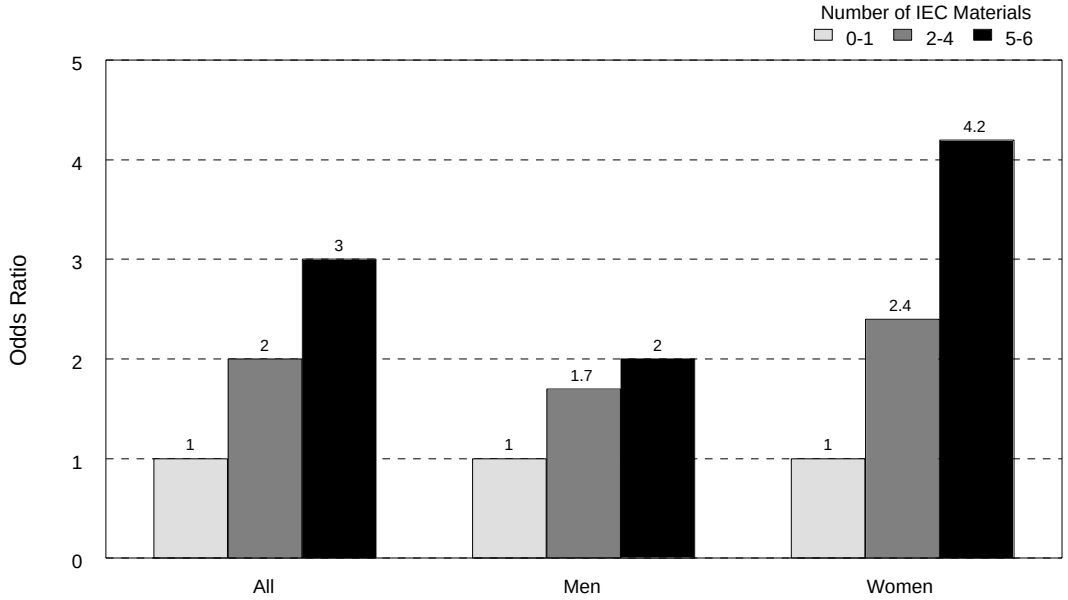
Analysis showed the same results for the family planning logo. As illustrated in Figure 7.12, those who had seen the logo were almost twice as likely to use family planning, with the same values for men and women. As shown in Figure 7.13, those who had seen the logo were 2.4 times more likely to be using a modern method. This was not the case for the radio drama, *Konoweeka*, however, and there were no major differences in contraceptive behavior among those exposed and those not exposed to the program.

**Figure 7.10.**
**Odds Ratios of Use of Any Family Planning Methods, by Number of IEC Materials Seen, Follow-up Survey, Uganda, 1994**



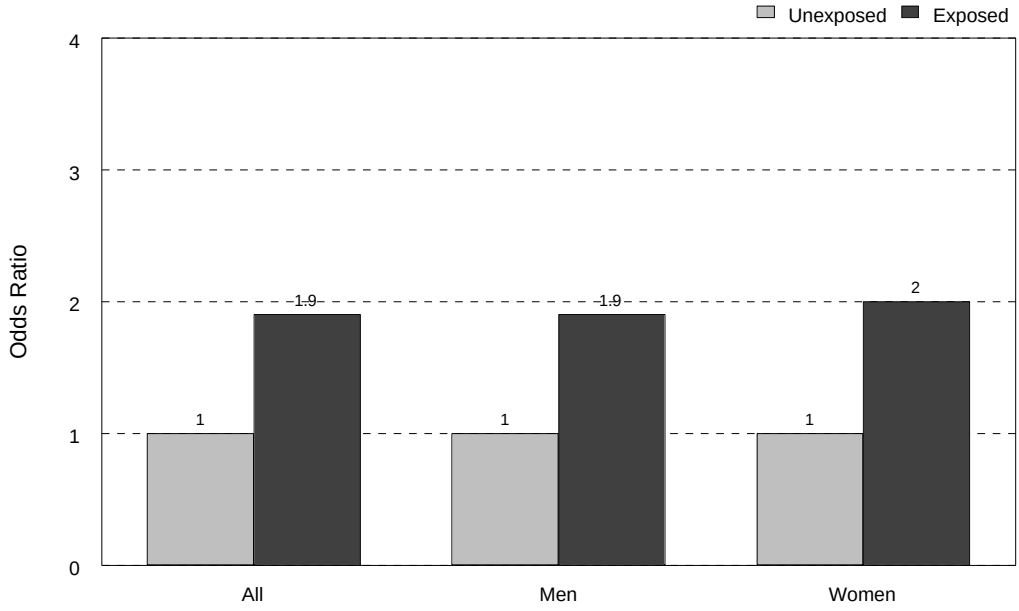

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n=1,125; unadjusted data.
Control variables: age, education, location, district, parity, family planning attitudes, possession of radio, TV, and car.

**Figure 7.11.**
**Odds Ratios of Use of Modern Family Planning Methods, by Number of IEC Materials Seen, Follow-up Survey, Uganda, 1994**



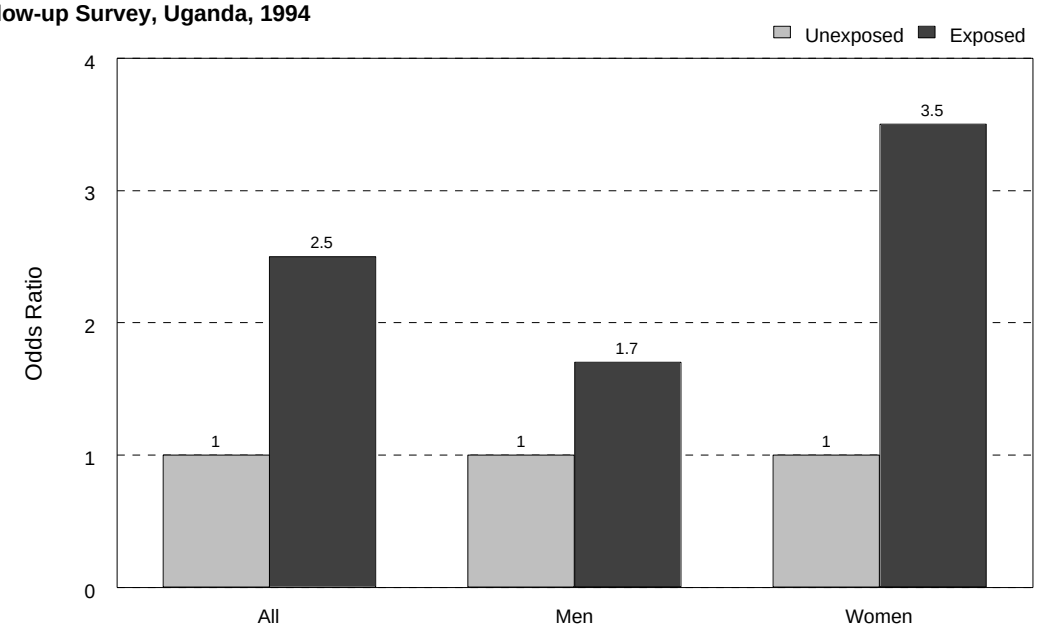

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n=1,125; unadjusted data.
Control variables: age, education, location, district, parity, and family planning attitudes, possession of radio, TV, and car.

**Figure 7.12.**
**Odds Ratios of Use of Any Family Planning Methods, by Exposure to Yellow Flower Logo Follow-up Survey, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n=1,125; unadjusted data.
Control variables: age, education, location, district, parity, family planning attitudes, possession of radio, TV, and car.

**Figure 7.13.**
**Odds Ratios of Use of Modern Family Planning Methods, by Exposure to Yellow Flower Logo, Follow-up Survey, Uganda, 1994**

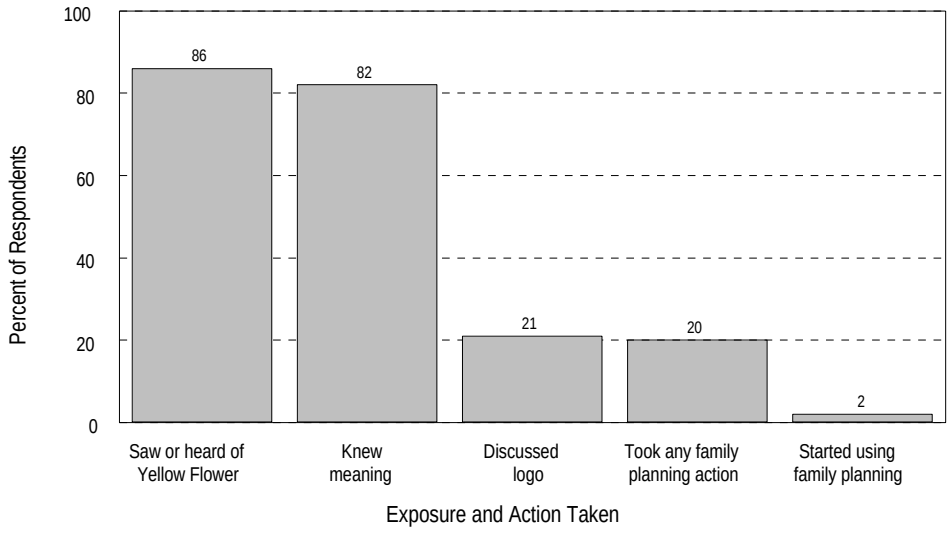



SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n=1,125; unadjusted data.
Control variables: age, education, location, district, parity, family planning attitudes, possession of radio, TV, and car.

**Actions taken as a result of exposure to the logo**. Central to the evaluation of family planning education campaigns is recognition that behavior change occurs over time and involves a number of stages. The process has various names; JHU/CCP refers to it as the "Steps to Behavior Change."[6] There are five major stages in this behavior-adoption model: awareness, persuasion, decision, implementation, and confirmation/ advocacy. Family planning communication has an influence at each stage as it moves individuals from one level to the next. Some individuals can move rapidly, others move slowly, while others remain at a given stage temporarily or permanently (*e.g.*, those absolutely opposed to family planning). Several components of the "Steps to Behavior Change" framework were used to assess the impact of the logo and of the radio program.

As described earlier, 86 percent of respondents had been exposed to the logo (see Table 7.1). All those exposed were asked what the logo meant, whether they had discussed the logo with anyone, whether they had taken any family planning action as a result of seeing the logo, and, if so, what action they had taken. Percentages were calculated using the entire sample as the denominator. About 21 percent of the total sample had discussed the logo; 20 percent had taken some family planning action as a result of exposure; and 2 percent had started using family planning (see Figure 7.14)

**Figure 7.14.**
**Steps to Behavior Change: Exposure to the Yellow Flower Logo and Actions Taken, Follow-up Survey, Uganda, 1994**

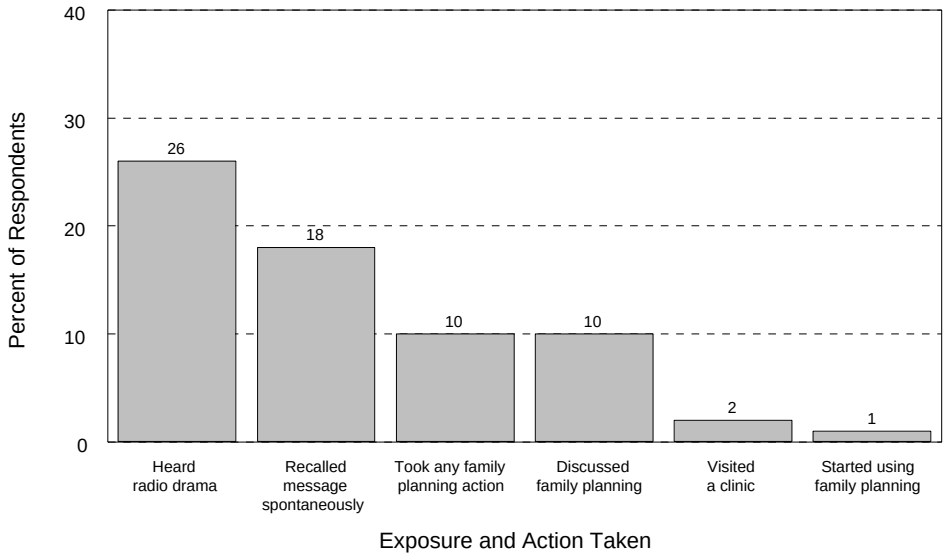



SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTE: n=1,323; unadjusted data.

[6] For further reference to the Steps to Behavior Change, see Rogers (1995) or McGuire (1989).

**Actions taken as a result of exposure to radio drama** The Steps to Behavior Change framework was also used to evaluate the impact of *Konoweeka* and the results are presented in Figure 7.15.

**Figure 7.15.**
**Steps to Behavior Change: Exposure to Konoweeka and Actions Taken, Follow-up Survey, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTE: n=1,323; unadjusted data.

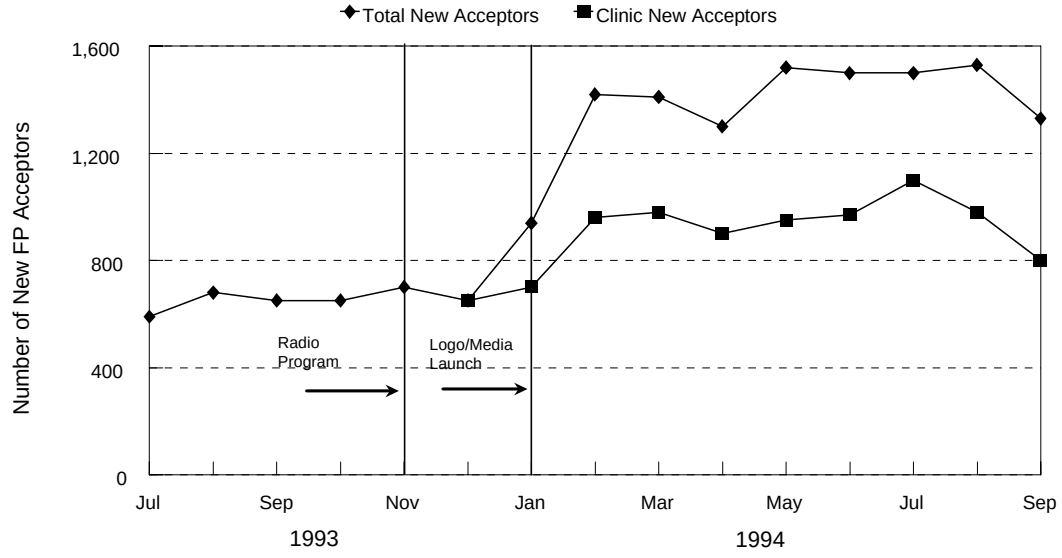
## Project Impact: Evidence from Clinic Attendance

Ultimate evidence of UFPPP impact was expected to be found in clinic attendance as more people sought family planning services during the campaign. To investigate, clinic service statistics for FPAU facilities were tracked over a 15-month period.

In anticipation of increased demand for family planning generated by the campaign, FPAU took measures to make supplies more widely available by permitting field educators (FEs) to act as CBD agents instead of referring all clients to clinics. Beginning in January 1994, FPAU authorized FEs to provide pills and condoms as well as make referrals. The results presented in this report are, therefore, for both clinic and community-based clients. Data show that clinic attendance began to rise after the logo launch, airing of the radio jingles and spots, and greater availability of services (see Figure 7.16). Before the campaign, the monthly average number of new users at the FPAU clinics was 643; it rose to 881 during the campaign.

The additional clients served by the FEs raised the monthly average to 1,255, a 94 percent increase over pre-campaign levels.

**Figure 7.16.**
**Monthly New Family Planning Acceptors at 24 FPAU Clinics and Field Educator Outlets, Clinic Statistics, Uganda, 1993-1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

## Project Impact: Evidence from Clinic Exit Interviews

To assess the UFPPP impact on service delivery, exit interviews were conducted with new family planning acceptors at selected clinics. Baseline interviews were conducted with 169 women at 24 clinics in March 1993 and follow-up interviews were conducted with 155 women in 21 of the same clinics in September 1994. Analysis revealed that there were no statistically significant differences in demographic characteristics between the baseline and follow-up samples (see Table 7.9). Both sets of interviewees were similar in terms of education, marital status, age, and number of children.

**Table 7.9.**
**Percent Distribution of Women Respondents by Education and Marital Status, Mean Age, and Mean Number of Children, Clinic Exit Interviews, Uganda, 1993 and 1994**

| Characteristic | Before Campaign (n=169) | During Campaign (n=155) |
|---|---|---|
| **Education** | | |
| None | 10.1 | 9.7 |
| Primary | 42.9 | 48.4 |
| Secondary or more | 39.0 | 41.3 |
| **Marital Status** | | |
| Married | 91.0 | 84.5 |
| Single (never married) | 6.0 | 11.0 |
| | 3.0 | 3.9 |
| Divorce/Widow/Separated | | |
| Other | 0.0 | 0.7 |
| **Mean age (years)** | 27.3 | 26.8 |
| **Mean number of children** | 3.7 | 3.7 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: n is the total sample for each survey.
No demographic characteristics showed significant pre- and post-campaign differences at $p \leq 0.05$.

**Contact with CBD agents**. Nearly 30 percent of clients had some contact with a CBD agent in the three months before the baseline. In the follow-up survey, this proportion increased to 34 percent, but this change was not statistically significant (p=0.37; see Table 7.10). In Uganda, CBD agents counsel clients one-on-one, conduct group education sessions, or address audiences in public meetings such as Resistance Council gatherings. Evaluation results show an increase in the percent of clients who reported attending a public lecture by a CBD agent (p=0.01), while other modes of contact were relatively unchanged. Clients were satisfied with the interaction—nearly all found the agents respectful and understanding and felt that the agents understood them and answered all their questions. The percent who said that the discussion with a CBD agent convinced them to visit a clinic also rose during the campaign.

**Table 7.10.**
**Percent of Respondents Exposed to CBD Agents and Type of Experience,**
**Clinic Exit Interviews, Uganda , 1993 and 1994**

| Experience with CBD Agent | Before Campaign (n= 169) | After Campaign (n=155) |
|---|---|---|
| **Seen/Had contact with CBD agent in past 3 months** | 29.6 | 34.4 |
| **Among those who had contact:** | | |
| Had one-to-one session with CBD agent | 44.4 | 35.9 |
| Had a group meeting with CBD agent | 42.6 | 67.9* |
| Had contact with CBD agent in RC or other meeting | 18.4 | 24.5 |
| Thought CBD agent was respectful | 97.7 | 98.1 |
| Client understood CBD agent | 97.9 | 100.0 |
| CBD agent understood client's problem | 95.8 | 86.5 |
| CBD agent answered all client's questions | 97.9 | 96.2 |
| **"Did discussion with CBD agent convince you to come to the clinic, or would you have come anyway?"** | | |
| Convinced | 52.0 | 56.6 |
| Would have come anyway | 48.0 | 43.4 |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the total sample for each survey. *Differences between baseline and follow-up significant at $p \leq 0.05$.

**Source of referral.** Clients were asked what motivated them to visit the clinic that day (see Table 7.11). After the campaign, radio became the second most frequently cited source (before the campaign, it ranked number six).

**Table 7.11.**
**Percent of Respondents Reporting Sources of Referral to Family Planning Clinic, Clinic Exit Interviews, Uganda, 1993 and 1994**

| Source of Referral | Before Campaign (n=169) | After Campaign (n=155) |
|---|---|---|
| Self | 44.4* | 32.9* |
| Friends | 33.1 | 41.3 |
| Spouse | 26.0 | 27.1 |
| Antenatal clinic | 24.9* | 14.2* |
| Hospital/Clinic worker | 21.9* | 36.1* |
| Radio | 18.3* | 38.7* |
| Relative | 16.0 | 15.5 |
| Field educator/CBD agent | 13.0 | 20.0 |
| Private doctor, Midwife | 7.7* | 15.5* |
| Public meeting | 6.5* | 1.9* |
| Poster | 3.6 | 2.6 |
| Newspaper | 2.4 | 0.7 |
| Leaflet | 1.8 | 2.6 |
| TV | 1.2 | 3.9 |
| Sign post | 0.0* | 3.2* |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: n is the number who answered the question. Multiple responses possible.
* Baseline and follow-up differences significant at $p \leq 0.05$.

**Clinic-based materials**. An important aim of the UFPPP was to make family planning materials more available to clients. Clients were shown samples of project materials and asked whether they had seen them during their visit (see Table 7.12). Although the wording of the questions differed slightly, there was a significant increase in reported exposure to project flipcharts, leaflets, and posters. In fact, after the campaign, 89 percent of clients had been exposed to some IEC material—up from 60 percent. Although these gains are encouraging, fewer than half of the clients surveyed were exposed to leaflets or anatomical charts.

**Table 7.12.**
**Percent Distribution of Campaign Materials Used During Clinic Visit,**
**Clinic Exit Interviews, Uganda, 1993 and 1994**

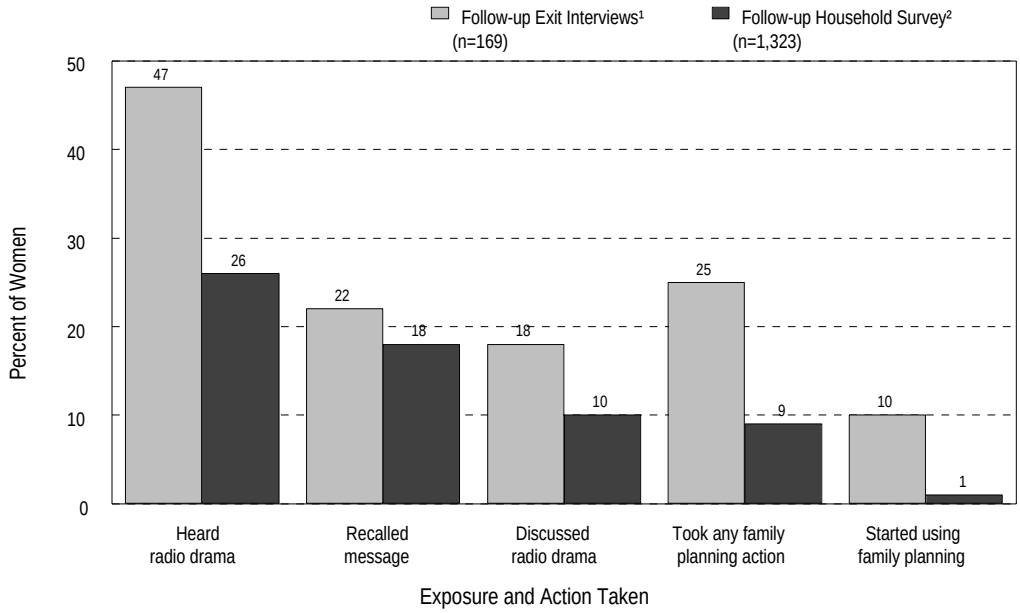
| Project Material | Before Campaign (n=169) | After Campaign (n=155) |
|---|---|---|
| Flipcharts | 50.9 | 61.9* |
| Anatomical charts | 39.5 | 42.6 |
| Leaflets | 14.8 | 38.1* |
| Posters | 12.3 | 68.8* |
| Any project print material | 60.4 | 89.0* |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: * Differences between baseline and follow-up significant at $p \leq 0.05$.
Baseline question: "During your visit at the clinic today, did the nurse show you any of the following materials?" Follow-up question: "During your visit at the clinic today, did you see any of the following materials?"

**Community-based materials**. Almost half of clinic attendees reported they had heard *Konoweeka* (see Figures 7.15 and 7.17). Approximately 22 percent could spontaneously recall a message from the drama, 18 percent discussed it with someone, 25 percent took some action, and 10 percent had reported accepting family planning as a result of exposure.

The "Steps to Behavior Change" framework was again used to compare exposure to *Konoweeka* among respondents in clinic exit interviews with the follow-up household survey respondents. The analysis is a comparison of the exposure and actions of women who changed behavior and women in the general population. Clinic respondents were almost twice as likely to report exposure to the drama and to have discussed it with someone, almost three times as likely to have taken any action, and nearly ten times more likely to begin using family planning as a result of exposure compared with women in the follow-up survey (see Figure 7.17).

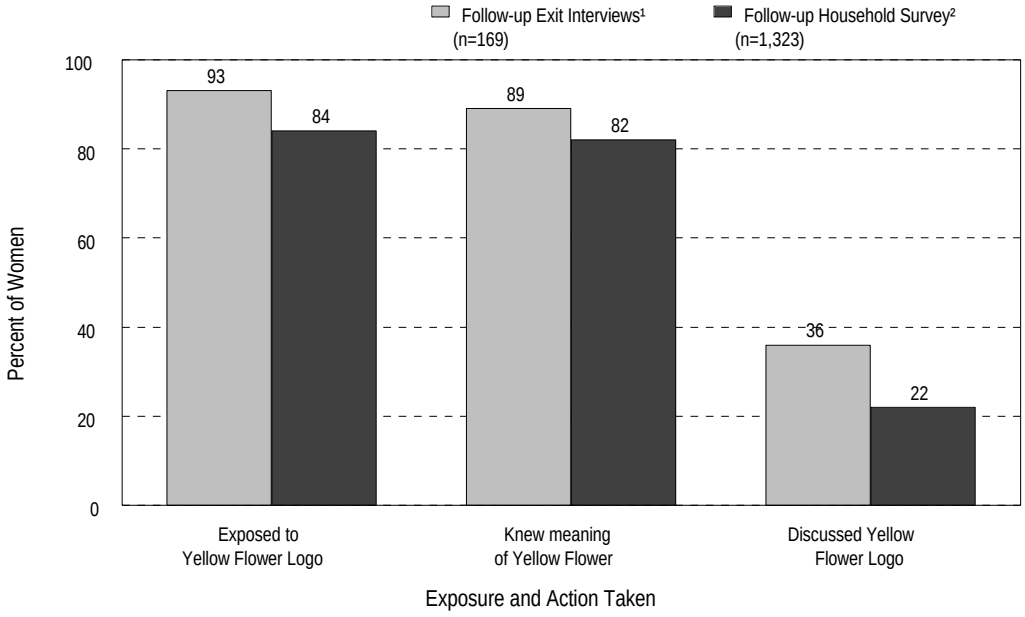
**Figure 7.17.**
**Steps to Behavior Change: Exposure to Konoweeka and Actions Taken, Follow-up Household Survey and Follow-up Clinic Exit Interviews, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: ¹ Exit Interviews conducted 9/94.
² Household Survey conducted 7/94.

A similar comparison was made with the Yellow Flower logo (see Figure 7.18). It is not surprising that clinic clients had greater exposure to the logo since it was placed in almost all family planning service delivery points. Clinic clients, however, were more likely than household survey respondents to have discussed the logo with someone.

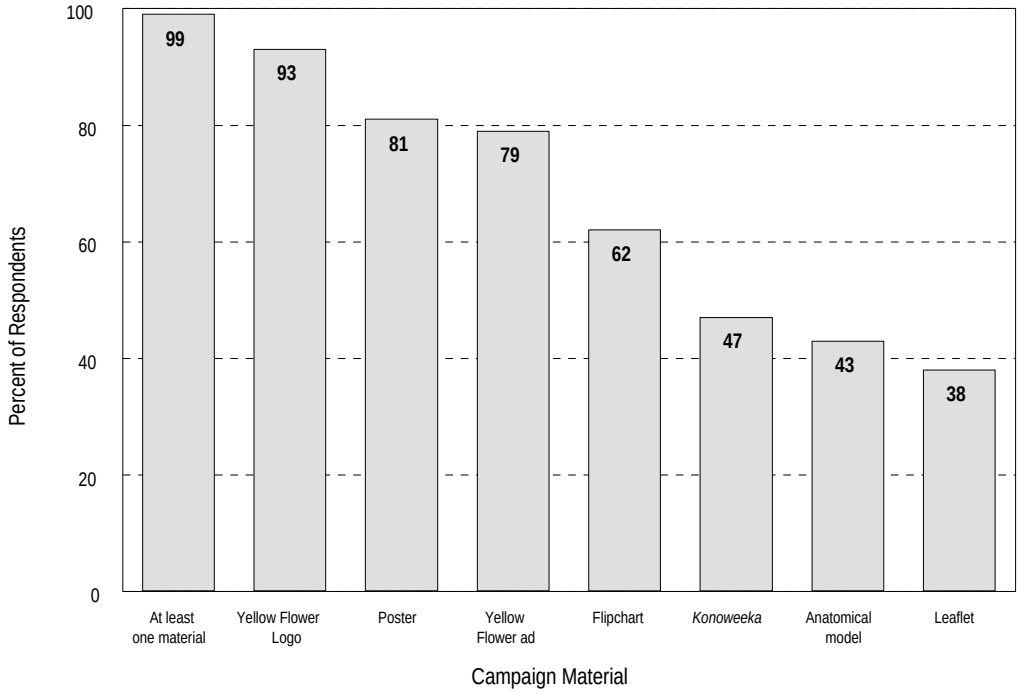
**Figure 7.18.**
**Steps to Behavior Change: Exposure to Yellow Flower Logo and Actions Taken, Follow-up Household Survey and Follow-up Clinic Exit Interviews, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: ¹ Exit Interviews conducted 9/94.
² Household Survey conducted 7/94.

**Overall exposure**. Virtually all (99 percent) of the clinic respondents had been exposed to at least one of the community-based or clinic-based IEC materials. (see Figure 7.19).

**Figure 7.19.**
**Campaign Materials Seen by Respondents,**
**Follow-up Clinic Exit Interviews, Uganda, 1994**




SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTE: n=155

# Chapter VIII.
# Conclusions and Recommendations

The main aims of the Uganda Family Planning Promotion Project (UFPPP) were to increase the use of modern family planning methods among married persons in campaign areas, to double the number of new clients at selected family planning clinics, and to increase the number of urban men with favorable attitudes toward family planning.

The project was launched in July 1992, and the main communication interventions of the campaign were implemented between November 1993 and October 1994. The project demonstrated that the Family Planning Association of Uganda (FPAU) could efficiently manage and implement a national campaign on behalf of the Ministry of Health (MOH). This leaves the MOH free to focus on other activities. The campaign also demonstrated that a diverse group of family planning agencies can collaborate to produce educational materials that many organizations can use. This strategy encouraged consistency among messages, while at the same time reducing costs that would have been incurred had each organization produced materials independently.

Three techniques were used to evaluate the project:

- Pre- and post-campaign household surveys among married persons in four districts,
- Monitoring of service statistics in FPAU service delivery points, and
- Pre-campaign and post-campaign client exit interviews at selected sentinel sites.

Results suggest that the campaign reached and affected a substantial majority of the populace; nearly 92 percent of the respondents in the post-campaign household survey and virtually all the clinic respondents reported having been exposed to at least one of the IEC materials. There was an improvement in perceived social support for family planning and an increase in those who do not desire any more children. Among contraceptive users, the proportion using modern methods rose from 69 percent to 74 percent. There were increases in the use of condoms, pills, and injectables. Use of nonmodern methods remained largely unchanged. The data suggest a shift from nonmodern to modern methods among respondents of lower education level as well as among those in the youngest age groups. In the FPAU facilities and FE distribution sites monitored for this evaluation, there was an increase in the number of new clients from a monthly average of 643 to a monthly average of 1,255, almost double the pre-campaign levels.

Logistic regression analysis found that the people recalling the most campaign materials were also the most likely to be using family planning, regardless of their age, gender, education, parity, attitudes toward family planning, socioeconomic status, and place of residence (*i.e.*, urban or peri-urban). Respondents with the highest campaign exposure were three times more likely to be using contraception than were those with no exposure and were also three times more likely to be using a modern method.

Many other factors operating in Uganda during the campaign could have affected fertility behavior. The findings of the evaluation, therefore, cannot be solely attributed to the project. For instance, several organizations were implementing health initiatives, such as the radio program *Capital Doctor*, Protector Condom advertisements, and other educational campaigns. External factors, such as economy, employment, overall changes in education level, and the AIDS epidemic can also have appreciable effects on consumer behavior. Nevertheless, the evidence is strong that UFPPP contributed positively to the family planning atmosphere in Uganda and served as an important education intervention to the public.

The following pages summarize the findings of the evaluation and suggests recommendations for future projects. They are addressed under the following broad categories: fertility and family planning, IEC interventions, HIV / AIDS and other STDs, breastfeeding, abortion, and IEC program management.

## Fertility and Family Planning

**Findings**
Nearly 40 percent of the respondents wished to have no more children, but of these, one-half were using no form of family planning. Among contraceptive users who do not desire any more children, one-fourth were using nonmodern methods, such as Natural Family Planning, periodic abstinence, withdrawal, breastfeeding, and local herbs.

***Recommendations***
*Future IEC interventions should directly address populations not using modern methods. Health care providers and community educators should address these groups as those with the greatest need and the most likely to respond positively. Special research and programmatic activities should be geared toward those who are not using family planning. Those who are using less-effective family planning methods should be informed about permanent and long-term methods if they choose to switch.*

**Findings**
Results show that more than 80 percent of people not using contraception would like to use contraception in the future. Younger nonusers with higher education are also the most likely to desire contraception in the future.

***Recommendations***
*Special efforts should be made to tailor messages for young, educated nonusers. These groups have sufficient education to enable them to take positive action. In addition, as nonusers actually begin to use, the need to expand service delivery should be anticipated. In particular, efforts that can make service delivery convenient for the client (for example, CBD) may be important.*

**Findings**
Roughly 58 percent of respondents had ever discussed with their spouses the number of children they would like to have. Respondents with no education (39 percent) were the least likely to have discussed their fertility goals, compared with 77 percent of those with post-secondary education.

***Recommendations***

*Couples should be encouraged to talk about the number of children they would like to have. Programs should address individuals in the lower education groups to inform them to control their own fertility. Discussions between spouses can be presented as models in radio dramas or other entertainment media. Because many people may be uncomfortable about controlling their own fertility, barriers hindering individual choice may need to be addressed.*

**Findings**

Nearly all respondents interviewed knew at least one method of family planning, and, on average, they knew 3.2 methods—2.7 modern and 0.4 nonmodern methods. This knowledge is largely superficial, however, and only after prompting did respondents recall additional methods. The method most commonly known is the pill. Condoms were recognized as a method of family planning mostly after prompting.

***Recommendations***

*Future public education programs should provide method-specific contraceptive information. Family planning providers should build on these efforts at the service delivery level. Education about family planning methods have been limited by the media. For example, at the time of the UFPPP project, it was not considered appropriate to use the word "condoms" on Radio Uganda, a main IEC channel used for the campaign. These apprehensions can limit free discussion of family planning. Efforts to allay the fears of media gatekeepers should be increased in future campaigns.*

**Findings**

There was an increase among those using modern methods. While 69 percent of users were using modern methods before the campaign, this number had risen to 74 percent by the end of the campaign (adjusted data). There was an increase in the use of condoms, pills, and Depo-Provera. There were unexpected drops in the use of IUDs and female sterilization. Use of nonmodern methods changed little. Overall, roughly 46 percent of follow-up survey respondents were using contraceptive methods compared with 50 percent in the baseline.

***Recommendations***

*Efforts to reach the 54 percent who are not using contraceptives should be intensified. In addition, although more users are using modern methods, many still rely on nonmodern methods. Future campaigns should focus on addressing these users to offer more reliable methods and information on how and where to obtain them. The evidence of switching from nonmodern to modern contraceptive methods among survey respondents provides confidence that, with correct information, users willingly move to more effective methods.*

**Findings**

A full 50 percent of persons not using family planning do not use because they desire more children, have just delivered, or are breastfeeding.

***Recommendations***

*Future campaigns should encourage nonusers who cite fertility-related reasons to space births and at the same time to set goals for moderate-sized families. Such campaigns should increase access to high-quality services and availability of public information about service locations.*

**Findings**
A major reason for not using family planning among those who do not cite fertility reasons is perceived inaccessibility of services and fear of real and rumored side effects.

***Recommendations***
*Efforts to increase access to contraceptives should be made. Systems should also be established to ensure adequate stock to clinics and CBD agents providing supplies. Education campaigns need to address the issue of side effects candidly. Radio and television dramas can dispel misconceptions about problems associated with specific methods. CBD agent talks at clinics or in other public forums can also address these topics. Appropriate print materials can also be developed. Providers should be trained to counsel clients about side effects and to inform them about positive steps to take when they experience discomfort. In addition, programs should use testimonials from satisfied users and provide opportunities for potential clients to interact with such individuals.*

**Findings**
Many women and men still associate family planning use with promiscuity, marital infidelity, and spousal mistrust. Infidelity may be especially disconcerting in the context of the HIV/AIDS epidemic in Uganda.

***Recommendations***
*Future communication efforts should reinforce the benefits of family planning for marital life. Programs can include testimonials from respected members of the community and from couples who use modern methods and have had long, happy marriages. Programs should also offer guidance in communication skills so that people can confidently broach the subject with their partners without fear or discomfort.*

**Findings**
Although family and community approval are not major obstacles to family planning use in Uganda, there is still room for improvement. Post-campaign responses indicated a significant increase in perceived approval, but religious leaders, mothers, and mothers-in-law are still seen as hindrances. In addition, men perceive less support for family planning from mothers and mothers-in-law than women do. This may cause husbands to be less receptive of family planning themselves and less supportive of their wives' use.

***Recommendations***
*Future campaigns should portray family members such as mothers or mothers-in-law in more supportive roles through characters in plays, mass-media public service announcements, or other channels to encourage mothers to support sons and sons-in-law in the use of family planning. The sympathetic view of family planning by many churches in Uganda should also be publicized on radio, at public meetings, or other venues. Where possible, future campaigns should also collaborate with churches and encourage their support for family planning.*

**Findings**
The considerable amount of reported discussion about family planning between individuals and their social network suggests that this subject is not taboo. Although the quality of information

exchanged or duration of discussions was not reviewed, the generally low level of family planning knowledge suggests that inaccuracies may be transmitted in these discussions.

***Recommendations***

*Future programs should continue to encourage communication about family planning using various mass media strategies. In addition to fostering dialogue, programs should provide accurate information about contraception and address the many rumors people may be hearing.*

**Findings**

The campaign results show that there was an increase in contacts with CBD agents among clinic clients, often in group talks. This is consistent with the campaign objectives, where CBD agents were trained to motivate clients through public addresses and Resistance Council meetings. CBD agents became an important source of information. There was an increase in CBD agents' contact with clients, an increase in the number of clients who cited CBD agents as their main source of information, and an increase in those who said that CBD were instrumental in the decision to come to the clinic.

***Recommendations***

*Capitalizing on current momentum, interventions should train more CBD agents and provide them with sufficient supplies. CBD agents appear acceptable to the community, and clients who had contact with them were generally satisfied with the service they received. Once recruited, CBD agents should receive ongoing training, and this should be an integral part of any comprehensive family planning education campaign.*

**Findings**

While radio became the main source of family planning information for men, health care providers continue to be the main source of information for women. There was a decrease, however, in the percent of respondents who cited antenatal facilities as a source of family planning information. This should be viewed with concern, because these facilities serve a group of repeat visitors who would potentially benefit from information about contraception.

***Recommendations***

*Future campaigns can reach women by providing opportunities for women to receive family planning information and services when they visit health care facilities for other reasons. All health care sites, including antenatal facilities, should be encouraged to continue informing clients about family planning.*

## IEC Interventions

**Findings**
The family planning logo was well recognized—nearly 90 percent of the respondents in the follow-up household survey had seen or heard about it. The logo materials were well-distributed and could be found all over the country. When compared with the radio drama, the logo was more likely to be associated with family planning use.

***Recommendations***
*Future campaigns should build on the high level of logo recognition by associating the Yellow Flower with motivating messages. In addition, since many nonusers cited lack of access to services as a primary deterrent to contraception, the family planning logo should be prominently displayed on all facilities providing contraceptive services and advice. Worn-out logo materials should be replaced periodically. Other markers, such as arrows directing users to the clinic or flags for CBD agent outlets, can display the logo to reinforce the link with family planning action.*

**Findings**
Radio became the number one source of family planning information during the project. Radio showed the highest gains over other sources as the source of information for new clients, more than doubling its share. Although the radio program in the UFPPP focused heavily on the disadvantages of large families, almost to the exclusion of other motivating messages, it nevertheless built a foundation for future campaigns.

***Recommendations***
*Future radio messages should capitalize on the efforts of the project's radio drama and address related topics such as the advantages of using modern family planning methods. Messages should also address side effects of methods, what to expect at clinics, spousal communication, marital fidelity and contraception, and other subjects that can motivate a listener to take action. Radio programs can also provide referral information about the location of service delivery sites and whom listeners can talk with at those sites.*

**Findings**
Two new FM radio stations have been licensed in Uganda—Capital Radio and Radio Sanyu. Although their transmission is limited to Kampala and its surroundings, they provide an important alternative to the government-owned Radio Uganda.

***Recommendations***
*Future campaigns should consider also using these two new FM radio stations for broadcast of their programs. Other strategies that future radio-based initiatives could adopt are inclusion of family planning messages in existing popular shows, such as talk shows and music and sports programs in addition to health shows.*

**Findings**
Anecdotal evidence reveals that public enthusiasm for *Konoweeka* dropped because of the repetition of topics addressed. Multivariate data analysis indicated that the program was not associated with behavior change, while the logo and logo-related activities were. Despite these

shortcomings, *Konoweeka* seems to have reached the peri-urban audiences and those with the least education. Thus, radio proves to be a good channel to reach the peri-urban and the less-educated audiences.

***Recommendations***

*Given that only one-fourth of the household survey respondents were exposed to the radio drama, more frequent airing and an increase in programing time from 15 minutes to 30 minutes or more should be considered in future. In addition, the drama could be made more attractive and at the same time provide more reproductive health education.*

**Findings**

Nearly 39 percent of the follow-up survey respondents said they lived in a house that had a television set. While television is not widely available in Uganda, certain segments of the population do have access to this medium. Many educational programs on television already exist and are being used to address various health issues such as HIV / AIDS, early marriage, and education for girls.

***Recommendations***

*Future campaigns targeting urban audiences should consider using television. Campaigns should also consider integrating their family planning messages into existing programming.*

**Findings**

There was almost a 50 percent increase in available IEC materials in clinics. There was an increase in the availability of flipcharts, anatomical charts, leaflets, and posters. Fewer than one-half of respondents had seen the anatomical charts or leaflets, however.

***Recommendations***

*IEC materials, especially anatomical charts and leaflets, should be made more widely available. Providers should be taught how to use the materials and how to instruct clients on the use of client-oriented materials such as leaflets.*

**Findings**

On average, respondents had been exposed to three campaign materials. There was a positive "dose-response" relationship between contraceptive use and the number of campaign materials that respondents recalled. The data show that the more messages clients were exposed to, the more likely they were to use contraception. This suggests that campaigns that provide only sparse exposure will have weak impact. In contrast, campaigns with intense exposure over an extended period of time are more likely to have the desired effect.

***Recommendations***

*Future campaigns should have a wide array of materials in sufficient quantities to maximize audience reach through high intensity of exposure over prolonged periods of time. This will ensure the effectiveness of campaign activities. Efforts should also be made to coordinate communication and service activities in order to maximize the synergistic effects of IEC.*

## HIV/AIDS and Other Sexually Transmitted Diseases

**Findings**

Many respondents, especially those with no formal education, were uncertain about their risk of HIV/AIDS. Men were more likely than women to consider themselves not at risk, despite the finding that 33 percent of them reported extramarital sex (compared with 8 percent of women).

***Recommendations***

*Future campaigns should continue to inform people how to assess their risk and how to protect themselves against the disease. The Health Belief Model has demonstrated that without a sense of risk, people have little motivation to change their behavior. In contrast, people who recognize HIV/AIDS disease as severe, who perceive themselves as susceptible to it, and who perceive the preventive measures against transmission of the disease as effective are more likely to adopt safer behavior (Saba* et al. *1994). Future campaigns should help people to determine whether their behaviors are placing them at greater risk and provide them with the skills necessary to avoid such risks.*

**Findings**

Among the 20 percent of respondents who reported extramarital sexual relations, there were virtually no education differentials. Given the level of expected underreporting on so sensitive a topic, it is likely that high-risk behavior is more prevalent than reported. In addition, respondents who reported extramarital experience were no more likely to consider themselves at higher risk for HIV/AIDS than those with no such experience. Those who did not use condoms at their last extramarital encounter were also no more likely to consider themselves at greater risk.

***Recommendations***

*Campaigns should continue to stress the importance of "lifetime monogamy," a challenge in the polygamous culture of Uganda. Anecdotal reports suggest that some consider monogamy to be involvement with one partner at a time (serial monogamy) as opposed to a single partner for life (lifetime monogamy). Individuals should also be informed of the hazards of unprotected sex, both within and outside of marriage.*

**Findings**

Roughly 18 percent of all respondents had been tested for HIV/AIDS; 23 percent of those reporting extramarital relations had been tested. Respondents with no education were the least likely to have been tested but the most likely to want to be tested. Those in the youngest age group were also the most likely to want testing.

***Recommendations***

*HIV/AIDS testing and counseling services should be made more widely available and affordable (or free) since many people have not been tested. Education interventions and testing facilities should be prepared to address any special concerns of younger audiences and those with no education, since they appear to be the most likely to want to be tested.*

**Findings**
About 77 percent of the respondents who had heard of HIV/AIDS or other STDs had changed their behavior since learning of them, and more than three-fourths opted for sexual monogamy. Persons with the least education and those in the youngest age groups, however, were the least likely to report any change. Respondents appear to have assimilated the importance-of-monogamy message to prevent HIV/AIDS and other STDs. As discussed earlier, many respondents reported recent extramarital experience, however.

***Recommendations***
*Campaigns should emphasize the use of condoms even within marriage as appropriate. Teaching culturally sensitive negotiation skills on the use of condoms should be an important part of any family planning service provision. Campaigns should target married persons to inform them about options available for protection against HIV/AIDS.*

**Findings**
There is still a general mistrust of condoms, with an odd differential in the perceived efficacy of condoms for HIV/AIDS *versus* other STDs protection. Respondents believed condoms break, have holes, and are difficult to use consistently. Only 60 percent felt condoms can protect against HIV/AIDS, while 72 percent expected condoms to protect against other STDs. One-tenth of those who had taken action to protect against HIV/AIDS and other STDs reported using condoms.

***Recommendations***
*Future campaigns should work to dispel rumors about condoms and encourage consistent use. Service providers and condom distributors should ensure that only high-quality supplies are available. They should demonstrate appropriate condom use, including how to open the package carefully, how to roll the condom on, when to put it on and take it off, and how to discard it; they should also allow clients to handle condoms in order to feel comfortable with them. Providers should also emphasize the fact that a new condom should be used at each sexual act. Clients should be informed about issues such as expiration dates, storage of condoms, and other factors that can affect efficacy.*

**Findings**
Nearly 62 percent of women respondents consider condom use within marriage appropriate, but only 46 percent of men agree. Data also show that condom use in extramarital relations is also a problem; 42 percent of those involved in extramarital relationships had not used a condom at last encounter.

***Recommendations***
*While women seem more willing than men to accept their partners' use of condoms, they may be reluctant if their partners object. Interventions should be developed to empower individuals, especially women, to request condom use. At the same time, interventions should encourage partners, especially men, to listen and be receptive to condom use.*

**Findings**
Data suggest that respondents were more likely to have discussed other STDs than HIV/AIDS. They were also more likely to say they would inform a partner if they had another STD than if

they were HIV-positive. This suggests that the stigma attached to HIV / AIDS is still strong, and many people appear uncomfortable about revealing HIV-positive status to partners, thus putting partners at risk.

***Recommendations***

*Education programs should encourage conscientious disclosure to partners. Such programs can model scenarios on radio or television programs teaching how to communicate sensitively with partners. In counseling clients, health care workers should encourage those who are HIV-positive to inform their partners.*

## Breastfeeding

**Findings**

Breastfeeding is common in the study area; 86 percent of the respondents (or their partners) had breastfed their youngest children. About 10 percent of current users of contraception reported breastfeeding as their method. While the average reported duration of breastfeeding was 14 months (excluding those still breastfeeding), respondents felt that a child should be breastfed for an average of 19 months.

***Recommendations***

*IEC interventions should continue to promote breastfeeding. Women relying on breastfeeding as a family planning method should be helped to understand how breastfeeding works as a contraceptive and to determine the point at which they may need additional family planning methods while breastfeeding.*

## Abortion

**Findings**

Although abortion is illegal in Uganda, it appears to be widely known—nearly two-thirds of the respondents said they were aware of a person who had had an abortion. Abortion is a sensitive issue, and its problems are further compounded by possible HIV / AIDS infection if conducted under septic conditions.

***Recommendations***

*Since abortion is restricted in Uganda, IEC interventions should focus on pregnancy prevention by providing information about contraceptive methods and by promoting sexual responsibility. This could be done at locations known to provide abortion during post-abortion counseling.*

## IEC Program Management

**Findings**

The Project Advisory Committee, formed by the UFPPP, worked well and resulted in a more efficient project. It kept service delivery focused, reduced the costs associated with the production of materials by each group, and enabled consistency in its messages to the clients.

***Recommendations***

*This administrative arrangement could be expanded in other education interventions, such as HIV/AIDS education, thus freeing the MOH to focus on other activities while still overseeing the intervention.*

**Findings**

The household surveys and the clinic exit interviews were efficiently conducted by private consultants specifically recruited for this task. This strategy made data available in a timely manner. Clinic statistics and information on referral sources, however, remained difficult to collect. While FPAU worked hard to oversee this activity, data collection at the clinic level appeared to have had a lower priority for clinic workers than other programmatic tasks. This problem is not uncommon in many African countries where family planning providers are already overburdened and may not consider data collection a priority.

***Recommendations***

*Private consultants should be considered for future data collection especially at clinic sites, since they may be better able to focus on data issues than already overworked health workers.*

# References


AIDS Control Program and World Health Organization, *An Evaluation and Study of Uganda AIDS Control Programmes Information, Education, and Communication Activities*, Uganda: Ministry of Health and WHO Global Programme on AIDS, July-December 1991.

Armitage, P. and Berry, G., *Statistical Methods in Research*, Boston: Blackwell Scientific Publications, 1987.

Family Planning Association of Uganda (FPAU), *Family Planning: We Cannot Use What We Do Not Understand! Qualitative Research on Family Planning in Uganda*, Kampala, Uganda and Baltimore: FPAU and Johns Hopkins University / Population Communication Services, 1992.

Kaleeba, N., "AIDS in Africa: The Ugandan Experience," *Tropical Medicine and Parasitology*, (44)2:128-30, 1993.

Kelsey, J.L., Thompson, W.D., and Evans, A.E., *Methods in Observation Epidemiology*, New York: Oxford University Press, 1986.

Kinoti, S.L., Gaffikin, L., Benson, J., and Nicholson, L.A., *Monograph on Abortion Issues in East, Central, and Southern Africa: With Policy Implications*, Arusha, Tanzania: The Commonwealth Regional Health Community Secretariat for East, Central, and Southern Africa, 1994.

Kiragu, K., Nyonyintono, R., Sengendo, J., and Lettenmaier, C., "Family Planning Needs in Uganda: Key findings from a Baseline Survey of Selected Urban and Peri-urban Areas," Kampala, Uganda and Baltimore: Family Planning Association of Uganda and Johns Hopkins University / Population Communication Services, 1993.

McGuire, W.J., "Theoretical Foundations of Campaigns," in Rice, R.E. and Atkin, C.K. (eds.), *Public Communication Campaigns*, 2nd Edition, Newbury Park, California: Sage Publications, 1989, pp. 43-65.

Museveni, Y.K., "AIDS and Its Impact on the Health, Social, and Economic Infrastructure in the Developing of Uganda," Proceedings of the VIIth International Conference on AIDS, Florence, June 16-21, 1991.

Population Reference Bureau, *1994 World Population Data Sheet*, Washington, DC: Population Reference Bureau, Inc., April 1994.

Rimon, J.G., Kiragu, K., Krenn, S.C., *et al.*, "The Impact of a Complementary Campaign on Family Planning in Nigeria," Presented at the 122nd Annual Meeting of the American Public Health Association, Washington D.C., 1994.

Rogers, E.M., *Diffusion of Innovations*, 4th Edition, New York: Free Press, 1995.

Saba, W.S., Valente, T.W., Payne-Merritt, A.P., and Kincaid, D.L., "The Mass Media and Health Beliefs: Using Media Campaigns to Promote Preventive Behavior," Baltimore: Johns Hopkins University / Population Communication Services, 1994.

Stata Corp., *Stata Reference Manual: Release 3.1*, 6th edition, College Station, Texas, 1993.

Uganda Ministry of Health and Institute for Resource Development (IRD) / Macro Systems Inc, *1988/1989. Uganda Demographic and Health Survey*, Entebbe, Uganda and Columbia, Maryland: Uganda Ministry of Health and IRD / Macro Systems, 1989.

Uganda Ministry of Finance and Economic Planning and Macro International, *1995 Uganda Demographic and Health Survey*, Entebbe, Uganda and Calverton, Maryland: Uganda Ministry of Finance and Macro International, 1996.

United States Agency for International Development, *USAID Responds to HIV/AIDS: A Report of the Fiscal Year 1994 HIV/AIDS Programs of the United States Agency for International Development*, Washington, DC, USAID G / PHN / HN / HIV-AIDS, 1995.

U.S. Department of Commerce: Bureau of the Census / Center for International Research, *Population Trends Uganda*, Washington, DC: U.S. Bureau of the Census, 1994.

Walker, R., "Uganda—Recent History," in: *Africa South of the Sahara, 1993*, 22nd Edition, London: Europa Publications, 1992, pp. 895-915.

WHO / UNICEF, "WHO / UNICEF Statement on Breastfeeding and HIV, WHO / UNICEF Consultative Meeting of April 30 – May 1," Weekly Epidemiologic Record, 67: 177–84. 1992.

# Appendix I.

**Table A.I.**
**Uganda Family Planning Promotion Project Campaign Events and Materials, 1992-1994**

| Campaign Event | Start Date | Description |
|---|---|---|
| 1.**Radio Drama**<br>Luganda<br>R/R/R/R [a]<br>Luo | November 1993 | 40 episodes each language, broadcast once a week |
| 2. **Radio Spots**<br>Luganda<br>R/R/R/R<br>Luo | January 1994 | 11 spots for each language per week, broadcast before the news for 6 months |
| 3. **Radio Jingles**<br>Luganda<br>R/R/R/R<br>Luo | January 1994 | A total of 74 jingles in the 3 languages for 3 months after morning and evening news |
| 4. **Posters**<br>Luganda<br>English<br>R/R/R/R<br>Luo | Mid-January 1994 | 20,000 posters in each language distributed |
| 5. **Family Planning Flip Charts** | January 1994 | 200 distributed to family planning clinics and to CBD agents |
| 6. **Anatomical Charts** | January 1994 | 500 distributed to family planning clinics and to CBD agents |
| 7. **Leaflets/Pamphlets**<br>Luganda<br>English<br>R/R/R/R<br>Luo | February 1994 | <br>100,000<br>20,000<br>50,000<br>20,000 |
| 8. **Training of Field Workers** | June 1994 | 10 trainers in male motivation & 256 CBD agents/grassroots FP workers |
| 9. **Loudspeaker Announcements** | May 1994 | 1,000 megaphones given to CBD agents |
| 10. **Signposts and Badges** | March 1994 | 600 signposts, one at each FP clinic; 10,000 FP badges, one for each service provider and trained satisfied user |
| 11. **Newspaper Ads** | February 1994 | New Vision 8<br>Ngabo 8<br>Orumuri 12<br>Etop 6<br>Rupiny 6 |
| 12. **Billboards** | July 1994 | 16 major towns |

NOTE: [a] Runyankore/Rukiga/Rutoro/Runyoro languages.

# Appendix II.

## Logistic Regression Tables

**Table A.IIa.**
**Estimated Adjusted Odds Ratios (and 95% Confidence Intervals) for Family Planning Use (Any Method) and Campaign Exposure (All Materials), Follow-up Survey, Uganda, 1994**

| Variable | All | Men | Women |
|---|---|---|---|
| **Campaign Exposure** | | | |
| 0-1 Materials | 1.00 | 1.00 | 1.00 |
| 2-4 Materials | 2.43 (1.62-3.63)* | 3.44 (1.73-6.81)* | 2.14 (1.28-3.59)* |
| 5-6 Materials | 3.29 (2.00-5.43)* | 3.98 (1.74-9.10)* | 3.38 (1.74-6.55)* |
| **Gender** | | | |
| Male | 1.00 | 1.00 | 1.00 |
| Female | 0.88 (0.66-1.17) | — | — |
| **Location** | | | |
| Urban | 1.00 | 1.00 | 1.00 |
| Peri-urban | 1.04 (0.79-1.38) | 0.93 (0.62-1.42) | 1.14 (0.77-1.67) |
| **District** | | | |
| Kampala | 1.00 | 1.00 | 1.00 |
| Jinja | 0.68 (0.48-0.96)* | 0.65 (0.37-1.12) | 0.70 (0.43-1.12) |
| Mbarara | 0.68 (0.46-098)* | 0.50 (0.28-0.89) | 0.96 (0.57-1.60) |
| Masaka | 1.17 (0.83-1.64) | 1.31 (0.77-2.22) | 1.20 (0.75-1.96) |
| **Education Level** | | | |
| None/Primary | 1.00 | 1.00 | 1.00 |
| Secondary | 1.32 (0.99-1.76) | 1.47 (0.93-2.32) | 1.33 (0.89-1.98) |
| Beyond secondary | 1.79 (1.21-2.63)* | 2.90 (1.65-5.09)* | 1.17 (0.67-2.07) |
| **Age** | | | |
| 20-24 | 1.00 | 1.00 | 1.00 |
| 25-29 | 1.24 (0.88-1.74) | 0.68 (0.34-1.34) | 1.35 (0.88-2.05) |
| 30-34 | 1.28 (0.87-1.89) | 0.77 (0.38-1.54) | 1.28 (0.78-2.11) |
| 35-40 | 1.30 (0.80-2.11) | 0.81 (0.39-1.71) | 1.78 (0.75-4.23) |
| **Owns a TV/Car** [a] | | | |
| Owns neither | 1.00 | 1.00 | 1.00 |
| Owns one of the two | 1.47 (1.10-1.98)* | 1.35 (0.86-2.13) | 1.47 (0.98-2.20) |
| Owns both | 1.73 (1.09-2.76)* | 2.26 (1.06-4.81)* | 1.51 (0.81-2.81) |
| **Owns a radio** | | | |
| No | 1.00 | 1.00 | 1.00 |
| Yes | 1.00 (0.70-1.43) | 1.02 (0.54-1.93) | 1.02 (0.65-1.59) |
| **Number of children** | | | |
| Less than 3 | 1.00 | 1.00 | 1.00 |
| 3 or more | 1.21 (0.91-1.63) | 0.80 (0.51-1.26) | 1.69 (1.11-2.57)* |
| **Attitude toward family planning** | | | |
| Opposed | 1.00 | 1.00 | 1.00 |
| Favorable | 1.57 (1.20-2.06)* | 1.69 (1.12-2.56)* | 1.42 (0.98-2.07) |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: * $p \leq 0.05$. n=1,125; unadjusted data.

[a] An indicator of socioeconomic status

**Table A.IIb.**
**Estimated Adjusted Odds Ratios (and 95% Confidence Intervals) for Family Planning Use (Modern Method) and Campaign Exposure (All Materials), Follow-up Survey, Uganda, 1994**

| Variable | All | Men | Women |
|---|---|---|---|
| **Campaign Exposure** | | | |
| 0-1 Materials | 1.00 | 1.00 | 1.00 |
| 2-4 Materials | 2.01 (1.27-3.31)* | 1.71 (0.76-3.85) | 2.40 (1.24-4.63)* |
| 5-6 Materials | 3.00 (1.66-5.33)* | 2.24 (0.87-5.80)* | 4.24 (1.95-9.22)* |
| **Gender** | | | |
| Male | 1.00 | 1.00 | 1.00 |
| Female | 0.52 (0.37-0.72) | — | — |
| **Location** | | | |
| Urban | 1.00 | 1.00 | 1.00 |
| Peri-urban | 0.94 (0.68-1.29) | 0.95 (0.58-1.53) | 0.91 (0.59-1.39) |
| **District** | | | |
| Kampala | 1.00 | 1.00 | 1.00 |
| Jinja | 0.84 (0.56-1.25) | 0.65 (0.35-1.22) | 1.00 (0.58-1.72) |
| Mbarara | 0.92 (0.60-1.40) | 0.53 (0.27-1.04) | 1.42 (0.80-2.51) |
| Masaka | 1.30 (0.89-1.90) | 1.09 (0.61-1.93) | 1.52 (0.89-2.59) |
| **Education Level** | | | |
| None/Primary | 1.00 | 1.00 | 1.00 |
| Secondary | 1.41 (1.01-2.00)* | 1.06 (0.61-1.84) | 1.74 (1.11-2.72)* |
| Beyond secondary | 1.47 (0.97-2.25) | 1.29 (0.69-2.43) | 1.65 (0.91-3.03) |
| **Age** | | | |
| 20-24 | 1.00 | 1.00 | 1.00 |
| 25-29 | 1.58 (1.06-2.36) | 1.49 (0.61-3.65) | 1.37 (0.85-2.20) |
| 30-34 | 1.71 (1.09-2.68)* | 1.43 (0.58-3.56) | 1.56 (0.89-2.73) |
| 35-40 | 2.34 (1.34-4.11)* | 2.09 (0.81-5.78) | 2.97 (1.20-7.41)* |
| **Owns a TV/Car** [a] | | | |
| Owns neither | 1.00 | 1.00 | 1.00 |
| Owns one of the two | 1.95 (1.41-2.69)* | 2.36 (1.43-3.89)* | 1.60 (1.03-2.47)* |
| Owns both | 2.24 (1.39-3.61)* | 3.19 (1.54-6.61)* | 1.72 (0.90-3.30) |
| **Owns a radio** | | | |
| No | 1.00 | 1.00 | 1.00 |
| Yes | 1.24 (0.80-1.94) | 1.63 (0.69-3.91) | 1.11 (0.66-1.89) |
| **Number of children** | | | |
| Less than 3 | 1.00 | 1.00 | 1.00 |
| 3 or more | 1.16 (0.83-1.63) | 0.75 (0.45-1.24) | 1.74 (1.09-2.78)* |
| **Attitude toward family planning** | | | |
| Opposed | 1.00 | 1.00 | 1.00 |
| Favorable | 1.75 (1.27-2.41)* | 1.49 (0.91-2.45) | 1.90 (1.22-2.95)* |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: * $p \leq 0.05$. n=1,125; unadjusted data.

[a] An indicator of socioeconomic status

**Table A.IIc.**
**Estimated Adjusted Odds Ratios (and 95% Confidence Intervals) for Family Planning Use (Any Method) and Exposure to Yellow Flower Logo, Follow-up Survey, Uganda , 1994**

| Variable | All | | Men | | Women | |
|---|---|---|---|---|---|---|
| **Logo Exposure** | | | | | | |
| Not exposed | 1.00 | | 1.00 | | 1.00 | |
| Exposed | 1.85 | (1.25-2.72)* | 1.92 | (1.01-3.62)* | 1.96 | (1.19-3.25)* |
| **Gender** | | | | | | |
| Male | 1.00 | | 1.00 | | 1.00 | |
| Female | 0.87 | (0.66-1.15) | — | | — | |
| **Location** | | | | | | |
| Urban | 1.00 | | 1.00 | | 1.00 | |
| Peri-urban | 1.05 | (0.80-1.39) | 0.93 | (0.62-1.41) | 1.15 | (0.79-1.70) |
| **District** | | | | | | |
| Kampala | 1.00 | | 1.00 | | 1.00 | |
| Jinja | 0.66 | (0.46-0.93)* | 0.63 | (0.37-1.09) | 0.65 | (0.40-1.04) |
| Mbarara | 0.63 | (0.43-0.91)* | 0.46 | (0.26-0.82)* | 0.89 | (0.54-1.48) |
| Masaka | 1.12 | (0.80-1.58) | 1.27 | (0.75-2.15) | 1.11 | (0.70-1.78) |
| **Education Level** | | | | | | |
| None/Primary | 1.00 | | 1.00 | | 1.00 | |
| Secondary | 1.39 | (1.04-1.85)* | 1.54 | (0.99-2.42) | 1.42 | (0.96-2.10) |
| Beyond secondary | 1.91 | (1.30-2.80)* | 3.10 | (1.78-5.41)* | 1.24 | (0.70-2.17) |
| **Age** | | | | | | |
| 20-24 | 1.00 | | 1.00 | | 1.00 | |
| 25-29 | 1.22 | (0.87-1.72) | 0.68 | (0.35-1.33) | 1.37 | (0.91-2.08) |
| 30-34 | 1.27 | (0.87-1.88) | 0.78 | (0.39-1.55) | 1.31 | (0.80-2.14) |
| 35-40 | 1.24 | (0.76-2.00) | 0.80 | (0.38-1.65) | 1.61 | (0.68-3.82) |
| **Owns a TV/Car** [a] | | | | | | |
| Owns neither | 1.00 | | 1.00 | | 1.00 | |
| Owns one of the two | 1.49 | (1.11-2.00)* | 1.37 | (0.87-2.14) | 1.48 | (0.99-2.21) |
| Owns both | 1.74 | (1.09-2.77)* | 2.34 | (1.10-4.94)* | 1.49 | (0.80-2.77) |
| **Owns a radio** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| No | 1.00 | | 1.00 | | 1.00 | |
| Yes | 1.13 | (0.80-1.60) | 1.28 | (0.70-2.35) | 1.11 | (0.40-1.04) |
| **Number of children** | | | | | | |
| Less than 3 | 1.00 | | 1.00 | | 1.00 | |
| 3 or more | 1.22 | (0.90-1.64) | 0.83 | (0.53-1.28) | 1.67 | (1.10-2.53) |
| **Attitude toward family planning** | | | | | | |
| Opposed | 1.00 | | 1.00 | | 1.00 | |
| Favorable | 1.62 | (1.24-2.12)* | 1.81 | (1.21-2.73)* | 1.45 | (1.00-2.10) |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).

NOTES: * $p \leq 0.05$. n=1,125; unadjusted data.

[a] An indicator of socioeconomic status

**Table A.IId.**
**Estimated Adjusted Odds Ratios (and 95% Confidence Intervals) for Family Planning Use (Modern Method) and Exposure to Yellow Flower Logo, Follow-up Survey, Uganda, 1994**

| Variable | All | Men | Women |
|---|---|---|---|
| **Logo Exposure** | | | |
| Not exposed | 1.00 | 1.00 | 1.00 |
| Exposed | 2.45 (1.44-4.17)* | 1.68 (0.74-3.78) | 3.48 (1.70-7.14)* |
| **Gender** | | | |
| Male | 1.00 | 1.00 | 1.00 |
| Female | 0.52 (0.37-0.71)* | — | — |
| **Location** | | | |
| Urban | 1.00 | 1.00 | 1.00 |
| Peri-urban | 0.94 (0.68-1.29) | 0.95 (0.59-1.53) | 0.91 (0.59-1.40) |
| **District** | | | |
| Kampala | 1.00 | 1.00 | 1.00 |
| Jinja | 0.81 (0.54-1.20) | 0.66 (0.35-1.22) | 0.92 (0.54-1.56) |
| Mbarara | 0.87 (0.57-1.32) | 0.51 (0.26-1.00) | 1.29 (0.73-2.28) |
| Masaka | 1.24 (0.85-1.81) | 1.09 (0.62-1.94) | 1.34 (0.79-2.27) |
| **Education Level** | | | |
| None/Primary | 1.00 | 1.00 | 1.00 |
| Secondary | 1.42 (1.01-1.99)* | 1.06 (0.61-1.84) | 1.79 (1.15-2.79)* |
| Beyond secondary | 1.52 (1.00-2.31) | 1.35 (0.72-2.52) | 1.67 (0.91-3.04) |
| **Age** | | | |
| 20-24 | 1.00 | 1.00 | 1.00 |
| 25-29 | 1.56 (1.06-2.33)* | 1.43 (0.59-3.50) | 1.39 (0.86-2.22) |
| 30-34 | 1.68 (1.07-2.64)* | 1.38 (0.56-3.43) | 1.57 (0.90-2.74) |
| 35-40 | 2.22 (1.27-3.89)* | 1.99 (0.77-5.09) | 2.69 (1.08-6.69)* |
| **Owns a TV/Car** [a] | | | |
| Owns neither | 1.00 | 1.00 | 1.00 |
| Owns one of the two | 1.96 (1.42-2.71)* | 2.41 (1.46-3.96)* | 1.60 (1.04-2.47)* |
| Owns both | 2.21 (1.38-3.55)* | 3.15 (1.52-6.51)* | 1.69 (0.88-3.23) |
| **Owns a radio** | | | |
| No | 1.00 | 1.00 | 1.00 |
| Yes | 1.35 (0.87-2.08) | 1.82 (0.77-4.30) | 1.18 (0.70-1.99) |
| **Number of children** | | | |
| Less than 3 | 1.00 | 1.00 | 1.00 |
| 3 or more | 1.19 (0.85-1.66) | 0.77 (0.47-1.27) | 1.72 (1.08-2.75)* |
| **Attitude toward family planning** | | | |
| Opposed | 1.00 | 1.00 | 1.00 |
| Favorable | 1.80 (1.31-2.49)* | 1.56 (0.96-2.54) | 1.95 (1.26-3.03)* |

SOURCE: JHU/CCP & FPAU Uganda Family Planning Promotion Project (1992-1994).
NOTES: * $p \leq 0.05$. n=1,125; unadjusted data.
[a] An indicator of socioeconomic status